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ABSTRACT

This document contains witness testimonies and prepared statements from the Congressional hearing called to examine the rise in health care costs and its effect on retirees' health benefits. Opening statements are provided from committee members. The retiree's perspective is given by a retiree and a granddaughter of a retiree who have had their health insurance terminated; and by a representative from the Midland Alive Coalition, a citizens' group concerned with the decision at one steel mill to terminate the medical benefits of former union employees now on pension. The views of experts in the field are presented by Anthony Gajda, an economist, and Donald Fuerst, an actuary from William M. Mercer-Meidinger, Inc. Mr. Gajda summarizes three regional surveys regarding post-retirement medical benefit plans, discusses businesses' concerns about rising retiree medical costs, and presents recommendations for change in retiree medical plans. Mr. Fuerst discusses the relationship between current retiree costs and ultimate retiree medical costs, and presents the Unit Credit, Entry Age, and Aggregate Methods as three ways to accumulate by retirement date the necessary reserve to fund an employee's benefits. The views of labor are given by the vice-president for human affairs for United Steelworkers of America, and the business perspective is discussed by the president of the Washington Business Group on Health, an organization for the health policy and cost management interests of major employers. Supplemental materials are provided throughout the document and in the appendices. (NRB)

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CORPORATE RETIREE HEALTH BENEFITS: HERE TODAY, GONE TOMORROW?

ED261292

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

JUNE 27, 1984

Printed for the use of the Select Committee on Aging

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CONTENTS

Members Opening Statements

	Page
Chairman Edward R. Roybal	1
Matthew J. Rinaldo	2
Mary Rose Oakar	3
Hal Daub	3
John Paul Hammerschmidt	4
Michael Bilirakis	4
Austin J. Murphy	68

Chronological List of Witnesses

August Anderson, retiree from the Bessemer Cement Co., Bessemer, PA	5
Sandra Nickelson, granddaughter of retiree from the Alpha Portland Cement Co., St. Louis, MO	9
Rev. Mike Garner, representing the Midland Alive Coaliton [MAC], Midland, PA	11
Anthony J. Gajda. economist, William M. Mercer-Meidinger, Inc., New York, NY	42
Donald E. Fuerst, FSA, William Mercer-Meidinger, Inc., New York, NY	47
Leon Lynch, vice president for human affairs, United Steelworkers of America, Pittsburgh, PA	55
Willis B. Goldbeck, president, Washington, Business Group on Health, Washington, DC	59

Appendix

Appendix 1. "Corporate Retiree Health Benefits: Here Today, Gone Tomorrow?" a briefing paper for a hearing of the House Select Committee on Aging, submitted for the record by Chairman Edward R. Roybal	99
Appendix 2. Additional material submitted for the record by Anthony J. Gajda, economist, William Mercer-Meidinger, Inc., New York, NY	108

CORPORATE RETIREE HEALTH BENEFITS: HERE TODAY, GONE TOMORROW?

WEDNESDAY, JUNE 27, 1984

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice at 1:10 p.m., in room 2212, Rayburn House Office Building, Hon. Edward R. Roybal (chairman of the committee) presiding.

Members present: Representatives Roybal of California, Oakar of Ohio, Rinaldo of New Jersey, Daub of Nebraska, Schneider of Rhode Island, Ridge of Pennsylvania, and Bilirakis of Florida.

Also present: Representative Murphy of Pennsylvania.

Staff present: Jorge Lambrinos, staff director; Steve McConnell, professional staff; Gary Christopherson, professional staff; Nancy Padilla, staff assistant; and Diana Jones, secretary.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Mr. ROYBAL. The hearing will come to order.

Ladies and gentlemen, today's hearing addresses a very serious problem that has only recently begun to surface. In response to rising health care costs, it appears that employers are beginning to back away from their promises to provide health benefits for their retirees. Thousands and thousands of retirees have already lost their health benefits and millions of retirees face an uncertain and very frightening future.

The problem is most serious right now in communities where plants have been closed in Midland, PA; Columbus, OH; Detroit, MI; Woodridge, NJ, retirees who were promised health benefits for what they thought was the rest of their lives have now lost their benefits. In other communities, benefits have been slashed. Many of the retirees are not yet eligible for medicare. Some are paying as much as one-half of their income to buy health care coverage. Most are simply doing without, running the risk of a catastrophe if they should need medical care.

Who is to blame? Now that is a question that is constantly asked. The blame rests on many shoulders. Employers have not kept the promise they made to retirees as they left the work force. The unions have not done an adequate job of protecting retirees through collective bargaining agreements. The President has promised dramatic changes in medicare which has frightened employers into someday thinking the major responsibility for retirees will fall on them. Congress has made reductions in medicare benefits that

shifts costs to employers. Retirees, like many others, have in some cases overutilized the health care system, thereby contributing to rising costs.

Pointing the finger at any of these groups does not solve the problem. The real issue is the astronomical rise in health care costs. Estimates are that for the Fortune 500 companies, the unfunded liabilities for retiree health benefits approaches $2 trillion, while the total assets of these companies is only $1.3 trillion. Health care costs have risen three times as fast as all other goods and services over the past 20 years.

Today, we hope to get some facts on the nature of the problem for many perspectives. We will hear from retirees who have lost their benefits; we will hear from business and from labor and from experts in the field. We will hear first hand about the misery created by broken promises, about the wrenching decisions faced by employers and unions who must deal with rising health costs, and about the devastating costs of sitting by and doing nothing. And we will hear about some solutions to the problem that will hopefully move us toward a more secure and healthy future.

The Chair will now recognize Mr. Rinaldo.

STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. RINALDO. Thank you very much, Mr. Chairman. I want to commend you for calling this hearing today to examine the problem of retired workers losing health care benefits. It's my understanding this is the first hearing of its kind ever held by any committee of Congress and I think it underscores the chairman's concern and my concern with this problem.

Faced with skyrocketing health care costs, more and more employers are cutting back on health benefits for retired workers. Retirees too young for medicare are particularly hard hit. Yet even those on medicare know too well that medicare pays far too little of an individual's health bill. A number of remedies to this newest health care crisis must be considered.

First of all, should the Employment Retiree Income Security Act be amended to provide that health care benefits for retirees are afforded the same protections as pension benefits? That would certainly be one way of solving the problem.

Should the Financial Standards Accounting Board adopt a rule to move unfunded liabilities for postretirement health care onto corporate balance sheets, thus forcing corporations to confront their obligations?

How should funding of retiree health benefits be treated for tax purposes? And, finally, what about medicare and health cost containment? In my view, Congress must leave no stone unturned in coming to grips with the problem. Congress, the administration, business and labor must work together and must immediately initiate a cooperative effort to ensure that the rights and expectations of older individuals are not compromised and that quality affordable health care is accessible to all older Americans.

Mr. Chairman, once again, I recognize the difficulty in getting a hearing scheduled during the last week in Congress when so many of our Members are so busy with so many other obligations, but I

think it's important we get this on the record and want to applaud your leadership in initiating this dialog on an extremely important issue facing everyone in this country.

Mr. ROYBAL. Thank you, Mr. Rinaldo.

The Chair now recognizes Ms. Oakar.

STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. OAKAR. Thank you, Mr. Chairman. I also want to join my colleague in commending you for this very important hearing. It's one of the largest problems that face so many pensioners and it's the kind of problem that we haven't really dealt with yet. I think this is an important hearing to adequately cover the situation.

Securing adequate health coverage is a major struggle for most older Americans today and so many factors conspire against their success. The cost of health care, for example, shoots up at a rate of three to four times faster than general inflation and medicare. We know medicare only covers 40 percent of the older Americans' needs. Every year we seem to see more drastic reductions in the program, meaning more and more out-of-pocket expenses for the elderly. Now we are experiencing the fact that employers are questioning whether they can deliver on their promise to provide retirees with adequate health coverage.

There is no question that health care inflation has reached a crisis proportion and that it's squeezing private and public sector budgets alike. But the real crisis is that the Government and the private sector, I believe, are dumping the problem of high health costs on the backs of the elderly. I think that's very unfair that our seniors have to assume the burden of high health costs as opposed to dealing with that situation head-on.

I hope that together we can have the resources, the wisdom, and the compassion to deal with what is a very terrible experience for older Americans as well as other Americans alike.

Mr. ROYBAL. Thank you, Ms. Oakar.

If there are no objections, I would like to submit the prepared statements of several of our colleagues for the hearing record at this time. Hearing no objections, so ordered.

[The prepared statements of Representatives Daub, Hammerschmidt, and Bilirakis follow:]

PREPARED STATEMENT OF REPRESENTATIVE HAL DAUB

Mr. Chairman, I want to commend you for holding this hearing today allowing us to examine the problems escalating health care costs are presenting to corporations which provide employee health benefit plans.

We are all aware of the importance of ensuring adequate health coverage for our growing senior population. For some retirees, an important supplement to their Medicare coverage is provided through employer health plans. Yet, as a result of spiralling health costs along with changing retirement ages and other modifications in the law, some corporations are uncertain of their ability to meet health care obligations in the future. Some companies have responded by redesigning their employee health benefit plans while a few others have eliminated coverage altogether. These changes present serious concerns to retirees who depend on these benefits.

Company initiatives to reduce the impact of rising health care liabilities have included a variety of approaches. Some include requiring staff to pay more of the first dollar costs in hopes of stimulating participants to become better health care consumers. In addition, wellness programs have been initiated and employees have been encouraged to utilize alternative delivery systems in communities in which they are available.

I am looking forward today to hearing the experiences and ideas of our witnesses and to solicit their idea concerning appropriate Congressional solutions.

One idea already included in legislation is to amend ERISA, expanding this 1974 law to include health benefits, as well as employee pension coverage.

As we develop solutions, it is important to consider the effects these proposal will have. We do not want to prevent companies from providing employee health plans in the first place.

Again, Mr. Chairman, I want to thank you for having this important hearing today.

PREPARED STATEMENT OF JOHN PAUL HAMMERSCHMIDT

Mr. Chairman, I want to compliment you for your foresight in holding the first congressional hearing on the issue of corporate-funded health care benefits.

Over the past few years this committee has been focusing a lot of its attention on Social Security and Medicare. We hadn't realized that at the same time thousands of retirees had lost employer-sponsored health benefits or had their benefits cut back due to plant closings, mergers or management decisions to reduce expenditures.

There are many factors which are converging to instigate these corporate changes. First, we have rising health costs. Since 1967 health costs have risen over 12 percent per year. Despite a decline in inflation in other sectors of the economy to 4 percent from 1981 to 1982, health costs were again up to 12.5 percent. In fact, health care has been taking a larger share of this Nation's resources rising from 6.4 percent of the GNP in 1967 to 10.5 percent in 1982. If we examine the effect of these increases on corporations, one larger company estimated that current annual health care costs for retirees range from $625 for those over 65 years of age and receiving Medicare to $2,000 for those under 65.

A second condition adding to the total cost of employer-sponsored health care is the ever-increasing number of retired workers and their trend of opting for early retirement. It has been noted in some industries that retirees outnumber current employees by 2 to 1. These are some of the probiems facing the employer.

Retirees have another set of problems. For many who unexpectedly have their premiums, deductibles and copayments rise, while living on pensions which are about half of their previous earnings, these changes are stunning. For those retirees who have their health benefits suddenly terminated, the blow is shattering. I think that it is important to note that the number of companies going out of business has been fairly significant. For just commercial and industrial companies with liabilities of over $100,000, over 27,000 have closed their doors since 1976. This is another part of the problem.

Today's hearing will give us an opportunity to look at both sets of problems—those faced by the retiree and those faced by employers. It will also allow us to look at some of the legislative and nonlegislative suggestions for resolving them. This is clearly an issue in which business, unions, government, economists and health care professionals can come together and work out these problems before they grow to any larger proportions. I want to thank the witness for giving us their views and recommendations on this important issue.

PREPARED STATEMENT OF REPRESENTATIVE MICHAEL BILIRAKIS

I, too, Mr. Chairman, want to commend you for calling this hearing on corporate retiree health benefit plans and the problems facing the retirees, who have either lost their benefits or are facing a serious reduction in the benefits programs promised to them—the results which can often have a devastating effect on our older Americans.

I also want to commend the Chair for addressing an issue that has not yet reached the point of crisis and can still be dealth with. Too often, we wait until we have reached a point, where relatively little or nothing can be done to correct a serious problem. Fortunately, the chairman has had the foresight in this instance.

The question we must answer, though, is what role the Federal Government is to take. A review of proceedings on this matter tells us that there is a definite problem at hand. We must now search and find the proper role for the Federal Government.

Again, I want to thank the Chairman and also thank our witnesses for being with us today.

Mr. ROYBAL. May I first of all thank the witnesses for their presence this afternoon? May I say to each one of you that members

will be coming in and out of this meeting. We have many functions going on at the present time and by functions I mean running the business of the Congress—not social functions. Having said that, I would like to now recognize the following witnesses: Mr. August Anderson, Sandra Nickelson, Rev. Mike Garner, Anthony J. Gajda, Leon Lynch and Willis Goldbeck.

Would you please proceed in any manner that you may desire and I will ask that Mr. Arthur Anderson to start the discussion?

A PANEL OF WITNESSES CONSISTING OF AUGUST ANDERSON, RETIREE FROM THE BESSEMER CEMENT CO., BESSEMER, PA; SANDRA NICKELSON, GRANDDAUGHTER OF RETIREE FROM THE ALPHA PORTLAND CEMENT CO., ST. LOUIS, MO; REV. MIKE GARNER, REPRESENTING THE MIDLAND ALIVE COALITION [MAC], MIDLAND, PA; ANTHONY J. GAJDA, ECONOMIST; DONALD E. FUERST, FSA., WILLIAM M. MERCIER-MEIDINGER, INC., NEW YORK, NY; LEON LYNCH, VICE PRESIDENT FOR HUMAN AFFAIRS, UNITED STEELWORKERS OF AMERICA, PITTSBURGH, PA; AND WILLIS GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC.

STATEMENT OF AUGUST ANDERSON

Mr. ANDERSON. Mr. Chairman, gentlemen and ladies, my name is August Anderson. I live in Bessemer, PA, where I worked at the Bessemer Cement plant for 33 years. On October 29, 1982, my health insurance was terminated. All past employees at that time lost their hospitalization. I should point out at this time that the personnel manager at our plant told past retirees prior to the shutdown that they would have hospitalization for life. This man sat in on all negotiations since these negotiations started and said that the pension would be there.

We filed a grievance, it went to arbitration and that arbitrator granted that all past retirees would be granted their hospitalization benefits until August 31, 1983. The company has not provided me with any benefits since that time. In order for me to convert and have the same policy that the company had would cost me $300 a month. I couldn't afford it. I don't think anybody in here could afford it.

So I tried to get a cheaper policy. I went to other carriers and when I told them that I had open heart surgery a few years ago, they said, "No way." It would be 2 years before I could be covered. That heart operation cost me $17,000.

I carried a cheaper insurance for my wife and I for 6 months and I couldn't afford it any more so I dropped it. Most of the former employees that I worked with have dropped their insurance. They don't have any. I never taken any medication in my life until the last months. I started to take a blood pressure pill when I started worrying about losing my hospitalization.

Now I bought this insurance from another company—not another company—let me retract that. There was an A and B plan on the insurance that I could take from the company. I couldn't afford the A plan so I had to go back to B. It was $200 a month. I had a stress test taken in January and I thought the hospitalization

would cover it. Well, I found out it didn't. They won't pay no outpatient coverage.

The doctor tells me the three main causes of heart disease are high blood pressure, stress and high cholesterol. I have high blood pressure and I am under a lot of stress now and I am a prime candidate for a heart attack.

My bank account is steadily decreasing. I hate to think of what would happen if my wife or I had to go to the hospital. I don't know what we would do.

The topic of conversation when I go into town is mostly about hospitalization and the hardship it has been causing on employees that don't have it. An awful lot of them are holding off on medical treatment because of it. I know there are many, many people out there in this great country of ours that are having the same problem that I am having. I am sure there is legislation that can be passed that can help us out.

Thank you.

[The prepared statement of Mr. Anderson follows:]

PREPARED STATEMENT OF AUGUST ANDERSON, BESSEMER, PA

My name is August Anderson. I live in Bessemer, Pennsylvania where I worked for the Bessemer Cement Company for 33 years until a contract dispute forced me to take early retirement. On October 29, 1982, my health insurance was terminated by Bessemer. All past retirees lost their hospitalization at this time. I should point out that all retirees were told by Mr. Shaffer, the personnel manager, that their pension and health insurance would be paid for life. The language in our contract clearly stated we should receive our pension and hospitalization for life.

Our union, of which I am an officer, filed a grievance and it went to arbitration in April 1983. The arbitrator granted that the company must reinstate our health benefits and reimburse us for payments that were made. These benefits were to be paid until our contract terminated on August 31, 1983.

As of August 31, 1983, the company has not provided me with health benefits. To convert my health insurance coverage, it would cost $312 per month for me and my wife. This would be for the same coverage we had under the company plan. I could not afford that amount. I had to take a lesser plan (which is for me only) at $254 quarterly. I had to stay with this insurance company because of pre-existing conditions. I had openheart surgery on June 1, 1982 which cost $17,000. With another health insurance company, there would be at least a 2-year waiting period for coverage. I bought insurance for my wife with another company which was cheaper ($224 for three months).

We carried this insurance on both of us for 6 months but with my pension at $905 per month less taxes, we could not afford it. We have had no health insurance coverage since April 1, 1984. Our health insurance from Bessemer is still in litigation. Most of the former employees could not afford paying the health insurance premium and have no insurance.

I have never taken any medication of any kind until January of 1984 when I started worrying about my health insurance. Now I take a blood pressure pill once a day. I had a stress test taken in January 1984. The insurance I had at the time would not pay for it. They would not pay for any outpatient treatment. I should have a stress test once a year. If they find any problems they need to correct them before they get too bad.

The doctor tells me that the three main causes of heart disease are high blood pressure, stress, and high cholesterol. So you see, I am a prime candidate for a heart attack. The stress test cost $265 plus $75 for the doctor. My bank account is steadily decreasing. I have never been late on a mortage payment, taxes or any payment in my life. I hate to think of what would happen if my wife or I had to go to the hospital. The topic of conversation when I meet former employees in town is hospitalization and the hardship it is causing them. There are an awful lot of them that are holding off medical treatment because they cannot afford it.

I know there are many, many people out there in this great country of ours that are having the same problems that I am having. I am sure that there is legislation that can be passed that can help us out.

BESSEMER CEMENT CO.,
SUBSIDIARY OF LOUISVILLE CEMENT CO.,
Bessemer, PA, October 12, 1982.

DEAR MR. ANDERSON: You were previously notified of your termination date of 9/30/82 or will be notified on or before 10/29/82. For those working beyond 9/30/82, it is possible that your termination date may be moved up should "mothballing work" be completed ahead of schedule. The 9/30/82 date has been fixed with the 10/29/82 date being the maximum period of time employees will work.

Several negotiation sessions have taken place with the Local and International Union on the effects of the closure. Attempts to reach a settlement have proved to be futile and an impasse has been reached. In view of this, the Company is going to carry out the following program of benefits for which we are contractually obligated.

Employees notified of their termination dates may elect to "creep" for 30 days upon written notice to the Company Personnel Office. This "creep" period may be extended for an additional 60-day period, a maximum of 90 days, upon written notice to the Personnel Office. During this "creep" period, employees gain only additional pension credited service. Employees must sign up at the Personnel Office by 10/29/82 to exercise this "creep" option. Other benefits will be handled as detailed in this letter.

BENEFITS

1. Health Insurance Benefits are to be canceled for retirees, future retirees and active employees at the end of October. Blue Cross has been so notified and you will receive a conversion notice from Blue Cross.

2. Life Insurance for retirees and future retirees will be canceled effective 8/31/83. Life insurance for active employees not retiring will be cancelled 10/31/82. Life insurance conversion forms will be available at the Personnel Office.

3. 1981 Vacation payable in 1982 will be paid to you if you have already taken your vacation.

4. 1983 Extended Vacation: For those who have not taken their extended vacation in the 5-year period beginning January 1, 1979 this benefit will be paid.

5. Severance Pay: For those not eligible for retirement, severance pay will be processed upon written request to the Personnel Office. For those eligible to retire, employees may request severance pay, but it will be deducted from any pension payment. In either case, payroll taxes and social security payments will be deducted from the gross amount. This election must be made not later than 30 days following your termination.

6. Pension: The Company intends to terminate the Pension Plan under the provisions of ERISA. We will be in a position in a few days to advise the Union and you of your basic pension under the Pension Agreement, which will require additional funding by the Bessemer Cement Company, should an agreement be reached on payment of all benefits. We will also advise you of the amount of your pension guaranteed by the Pension Benefit Guarantee Corporation in the event an agreement with your Union cannot be reached on benefits.

7. SUB: The SUB Plan is being terminated and available funds will be distributed in accordance with the objectives of the plan and subject to agreement by the Company and the Union.

If you have questions concerning this matter, feel free to contact the Personnel Office.

The Union has asked me to advise you that it takes exception to some of the above benefit provisions.

Sincerely,

H.A. SCHAFFER,
Personnel Manager.

BESSEMER CEMENT CO.,
SUBSIDIARY OF LOUISVILLE CEMENT CO.,
Bessemer, Pa., October 22, 1982.

DEAR MR. ANDERSON: We recently announced that the Bessemer Cement Plant would be permanently shut down effective September 30, 1982. You are hereby notified that you will not work beyond the current week's schedule and your termination is effective October 29, 1982.

We regret that this action is necessary.

Sincerely,

HAROLD C. LIPP,
Plant Manager.

BESSEMER CEMENT CO.,
SUBSIDIARY OF LOUISVILLE CEMENT CO.,
Louisville, KY, March 30, 1983.

DEAR FORMER EMPLOYEE: On March 29, 1983, Bessemer Cement Company sold most of its assets and properties to SME Bessemer Cement, Inc.

Questions concerning your former employment with the Bessemer plant should be directed to the address listed below.

Sincerely,

D. JACK COALE.

BESSEMER CEMENT CO.,
SUBSIDIARY OF LOUISVILLE CEMENT CO.,
Louisville, KY, April 22, 1983.

TO FORMER EMPLOYEES, ELIGIBLE RETIREES AND SURVIVING SPOUSES: As part of the award granted under Grievance No. 200, Arbitrator Herbert W. Sherman ruled "that the Company must reinstate the PIB (Program of Insurance Benefits) and must reimburse participants for only bills that they have paid which have been covered by PIB. The Company also must reimburse any active employees who have converted their insurance and have paid premiums for individual hospitalization insurance."

Blue Cross/Blue Shield refuses to reinstate the insurance program without a substantial premium increase. Therefore, Bessemer Cement Company has arranged with Liberty Mutual Insurance Company to reinstate the Program of Insurance Benefits. Liberty Mutual will provide the exact same coverage as Blue Cross and the Company will maintain this coverage until the Contract expiration date of August 31, 1983.

To reinstate your insurance benefits, we need for you to complete and return the attached questionnaire by Friday, May 13, 1983.

If you should need insurance forms, please direct your request to: Insurance Claims, Bessemer Cement Company, P.O. Box 35750. Louisville, Kentucky 40232.

After you have obtained the correct forms for processing your claim (completed forms and charges) should be returned to: Group Claims, Liberty Mutual Insurance Company, P.O. Box 35220, Louisville, Kentucky 40232.

If you have any questions with regard to this information, please don't hesitate to contact me.

Sincerely,

SARAH F. KUNERT,
Personnel and Benefit Coordinator.

Attachment.

BESSEMER CEMENT CO.,
SUBSIDIARY OF LOUISVILLE CEMENT CO.,
Louisville, KY, August 22, 1983.

To: Bessemer Hourly Individuals

As we have advised you previously, your health insurance coverage terminates August 31, 1983, at the end of the contract. If you wish to convert your coverage under Liberty Mutual, and you are under age 65, we are attaching a form for you to complete and forward to Liberty's Boston office immediately. However, Liberty Mutual does not have a conversion plan for individuals over 65 years of age. Therefore, in those circumstances, you should contact Blue Cross/Blue Shield. We have contacted the Butler Blue Cross office, and it is our understanding that they will make a conversion policy available to you.

If you have any questions with regard to this information, please don't hesitate to contact Sarah Kunert or myself.

Sincerely,

ROBERT L. ROSENBERGER,
Vice President-Secretary.

BESSEMER CEMENT CO.,
SUBSIDIARY OF LOUISVILLE CEMENT CO.,
Louisville, Ky, August 30, 1983.

To Bessemer Retirees (Under Age 65)

Previously we mailed you an application for conversion of your Liberty Mutual health insurance coverage to an individual contract upon expiration of the Insurance Agreement on August 31, 1983.

As another alternative, we have arranged with Liberty Mutual to continue your present retiree health coverage on the following conditions:

Seventy five percent of the retirees under age 65 and presently receiving coverage elect to continue the present coverage on an individual basis.

Liberty Mutual will continue the coverage only on the condition that the Bessemer Cement Company collects the monthly premiums and pays the premiums over to Liberty Mutual in a single sum.

The cost of the coverage is $312 per month which includes your dependents.

If you wish to continue your coverage, your check in the amount of $312 must be received by September 10 and by the first of each succeeding month that you wish to continue to be enrolled in the Plan.

It should be noted that one of Liberty Mutual's individual conversion contracts, outlined in the information previously mailed to you, may better suit your needs from the coverage standpoint and/or the premium cost standpoint. This election is yours. When you become 65 and are eligible for Medicare, it is my understanding that you can then join the Blue Cross Plan for those age 65 and over at that time.

If you have any questions with regard to this information, please contact Sarah Kunert.

Sincerely,

ROBERT L. ROSENBERGER,
Vice President-Secretary.

Mr. ROYBAL. Thank you; Mr. Anderson.
Sandra Nickelson.

STATEMENT OF SANDRA NICKELSON

Ms. NICKELSON. Ladies and gentleman, my name is Sandra Nickelson and I am here to testify on behalf of my grandfather, Leonard Verble, who was an employee of Alpha Portland Cement Co. for 27 years. I have lived with my grandparents all of my younger years up until 15 years ago. All through that time, I was aware of my grandparents' bills. I was also aware of their medical needs. When one of them went to the doctor or hospital, I was always there. Therefore, I knew of their medical benefits. I helped my grandfather make out claim forms. I asked my grandfather about getting medical insurance and he told me that he did not need to because, whatever the bill was, the insurance through Alpha Portland Cement Co. would cover it. He told me that up until he passed away he was guaranteed those benefits and that he also had a burial policy. He was well satisfied. That is, up until a few years ago when Alpha Portland Cement Co. notified us that all benefits were being cut. We were told we could pick up the coverage but my grandfather's health and high premiums prevented him from doing so.

My grandfather was a good worker and through the 27 years of employment he might have missed a week or so, but he gave them a commitment of those 27 years and all he expected in return was for them to live up to their promise to pay for his medical needs. But because they reneged on their promise my grandfather had to spend all of his savings and now I have had to step in and pick up his and my grandmother's medical costs. I have spent all my savings and have now taken a job to pay for them. As a result of my taking a job, I have had to place my grandparents in a nursing home. We have just gotten to the point where we are all suffering tremendously.

I have talked to several other retired employees of Alpha Portland Cement and many of them are unable to obtain medical help because of high premiums and high deductibles. It seems they can only obtain policies such as $500 deductibles or cannot afford any coverage at all. Most of the tests and similar things they need done

to them are under that $500 so they cannot afford to have them done. Many are in poor health, as are their wives. I think this is Alpha Portland Cement Co.'s responsibility because they took these men's youth and health. They promised these men medical benefits until their demise. Then they stripped these men of all dignity and forced some of them on welfare. Many are just plain forced to do without and suffering a great many medical problems.

What I am here to ask is how can you let companies take away something that these men worked so hard to obtain? How can a country as rich as ours let big companies or any company such as Alpha Portland Cement Co. get away with this? Can't a Federal regulation be imposed to stop these companies from taken away a family's savings and forcing them to fall prey to the welfare system? How would you feel if after 30 years at your job all of this happened to you?

Think about it. Thank you for letting me testify today.

[Additional material submitted by Ms. Nickelson follows:]

ALPHA PORTLAND CEMENT CO.,
A DIVISION OF ALPHA PORTLAND INDUSTRIES, INC.,
Easton, PA, December 15, 1981.

R.F. DE GROOT,
St. Louis MO.

This will confirm your retirement from Alpha on December 31, 1981. On or shortly thereafter you should receive your first monthly pension check in the amount of $510.76. If at any time you do not receive your pension check, please notify us. Ordinarily, your pension would have amounted to $549.80 per month; however, this has been reduced because of your election naming your wife as your joint annuitant. In the event you predecease her after your retirement date, she will receive $255.38 each month for the remainder of her life.

Your life insurance will be continued in the amount of $4,000. The balance of your life insurance will be continued until 31 days from your retirement date. Until then, you may convert it to an individual policy without the necessity of a physical examination. Application may be made by completing the enclosed Notice of Conversion Privilege form. Alpha group hospital and surgical insurance for you and your eligible dependents will be continued. Hospitalization benefits will be limited to the hospital's regular charge for semi-private care for a total of 365 days. Surgical benefits will be paid on a regular and customary basis. Major medical expense benefits will be provided up to a lifetime maximum of $5,000. These maximums apply to you and your eligible dependents separately. Our plan does not permit continuance of weekly indemnity, basic diagnostic expense and dental expense benefits. When an individual attains age 65 (in some cases sooner where a disabled individual is entitled to monthly cash benefits under the Social Security Program), he (or she) is eligible for Social Security's Medicare Program. The hospital, surgical and major medical benefits described above will be reduced by any benefits payable by Medicare. We strongly urge that you subscribe to the voluntary portion of Medicare; that is the part that costs $9.60 per month. This part of Medicare is also used as an offset against the Alpha benefits. Therefore, it is important that you and your spouse subscribe for the full Medicare Program when eligible. Alpha will reimburse you for the $9.60 cost, upon receipt of a copy of your Medicare card. Reimbursement will be included in your pension check.

ALPHA PORTLAND CEMENT CO.,
A DIVISION OF ALPHA PORTLAND INDUSTRIES, INC.,
Easton, PA, March 29, 1982.

R.H. JUERGENS,
Arnold MO.

DEAR HOURLY RETIREE: This is to notify you that effective May 1, 1982, Alpha is cancelling group insurance coverage on all retired employees and their dependents. Claims for hospital, surgical and covered major medical expenses, incurred through April 30, 1982, should be submitted in the usual manner.

We recognize this may create a financial problem for many of you, but the cost of this program has grown to such proportions that we have no alternative. Rather than have the insurance program end abruptly and without notice, we have selected May 1, 1982 as the termination date, which should allow you time to secure alternate coverage.

Although Alpha Company officials have had numerous discussions with officials of the Cement, Lime, Gypsum and Allied Workers International Union concerning this matter, the parties have reached an impasse. The Union has been informed of the decision to discontinue coverage as of May 1, 1982 and of this advance notification to you.

Our insurance carrier, The Equitable Life Assurance Society, has agreed to permit you to convert you life and health insurnace coverages to individual poilicies at your own expense. A Notice of Conversion Privilege and post cards requesting conversion information are enclosed. Converting your insurance, means that you may buy a policy of insurance from The Equitable Life Assurance Society without having to pass a medical examination. Equitable's converted health insurance coverage is available only to those ineligible for Medicare by reason of age. If you desire to convert your health insurance, the post card must be mailed before May 31, 1982.

Very truly yours,

R.J. BONSTEIN,
Personnel Manager.

Mr. ROYBAL. Thank you, Ms. Nickelson.

The Chair now recognizes the Reverend Mike Garner.

STATEMENT OF REV. MIKE GARNER

Mr. GARNER. Mr. Chairman, ladies and gentlemen, we have all been on thrill rides before, including a roller coaster. I liken this situation to a roller coaster because we have all felt the physical effects, the highs and the lows—perhaps for the more squeamish of us, the nausea that I have often felt. The same effect has been felt by hundreds and thousands and tens of thousands of people throughout this Nation.

You have heard testimony already on some of these effects, some of those emotional problems and traumas that people have struggled with. I believe that Midland and the situation there is very typical of what has happened at these other places and is happening throughout this Nation.

The elements of this emotional roller coaster—and I would like just to summarize because much of it is in the written testimony before you are briefly these: In early 1982 there were rumors of the Crucible Steel Mill being closed. The mill is the only source of income in our area and the only tax base for Midland.

Colt Industries came out to individual communities in town meetings they initiated, and promised that they would not shut down the mill. "There is no problem," they said, "We will not close the mill." Then came news that agreement had been reached between the Steelworkers Union and Colt Industries. Only a day later, however, Colt announced that their mill was for sale and they were not going to honor those agreements.

A possible new owner came into the picture, Universal Cyclops. They negotiated an agreement with the union. Everything was settled and people were up again, riding a high. And then Colt announced only a few days later that they were not going to sell to Cyclops. No explanation offered. Scraping bottom once again.

Finally, a new owner did come, J&L Industries, who owns the mill now but employs only one-fifteenth of the original work force. There are no jobs in sight either in Midland or in the tristate—

Pennsylvania, Ohio, and West Virginia—area in which we work. But to add injury to insult, when we thought all was said and done we learned that actually it was not over yet.

I wish to make clear from the start that I am here as one person but representing over 1,000 people who have shared with us at town meetings and have given us the opportunity and permission to speak for them. The people I am here to represent had thought that everything was finished, that they had nothing left to lose. There were only two things that they did have left—their pensions and their health benefits. But they were not concerned about either because they had been promised both would last for life—they had been promised in the contract, they had been promised in the 1977 steel settlement, which under the context of plant shutdown specifically states that the intent of that settlement is to have lifetime health benefits for these people. They had been promised through exit intervews. Over 1,000 pensioners sat down face to face with top Crucible management and were promised specifically at these exit interviews that they would receive health insurance for life. We have a tape in our possession of one man who was able to tape his interview. The interviewer, a Crucible management individual, says specifically, "You don't have to worry about your health benefits for you or for your wife in case you were to die, because that's part of the contract and it's assured for life." He was very specific. There was no question about it in the people's minds.

People had made decisions based on these promises—decisions about where to locate, where to live, how to spend their money, how much they could help their children who also were suffering through unemployment. They had made decisions a long time before that in deciding where they were going to work. Part of the decision to work at a Crucible steel mill was that you would receive health benefits for the rest of your life. That was part of their employment package and everyone's understanding.

In October, 1983, Colt Industries sent a letter to the union stating their intentions to cut off the pension benefits that everybody had assumed were theirs for life because of the promises. That information was not made public until a few months later—November 30—at a Midland Alive Coalition meeting—of which I am the president; 250 people came, showing great concern and wondering what in the world was going on. They couldn't believe it. They hadn't heard anything it. Later on, as 1,000 people gathered to share with us that they wanted us to do something about this situation, we began our active role and since then we have been involved in a fight with Colt Industries and it certainly has been a fight.

Although in February 1984, we won a temporary reprieve, it is really only a stay of execution because if negotiations between the union and Colt do not work out by February 28, 1985, this will all go back into court again. I should add that a similar case involving Yardman lasted 6 years in the courts. Part of that time no health insurance was provided for those people. The union finally won that case. But I think this insurance blackout is probably the most distressing side effect and if there is one thing I would like you to remember is that corporations such as Colt Industries is using the hardship that individuals would face as leverage in containing

their costs. I need to make it clear that we have no problem with the idea of cost containment. We all have to suffer with rising bills and with steady incomes. In fact, the people of Midland, PA, have to suffer just as much or more than anybody else, as I would estimate that the unemployment in our town is over 60 percent at this time. So we all understand is rising costs and we have sympathy for people trying to contain their costs. But the real issue is simply this: Just because your costs are rising, does that mean you can renege on your obligations?

Because my food bill goes up, I as an individual, cannot go to my bank and say, "I can't pay my car loan this month." They wouldn't hear of it. Neither should corporations be allowed to do that. Containing costs, therefore, is part of a much larger issue.

Colt has been using the hardship people would face as leverage and the basis for making this threat—and I would call it a threat. As far as we can understand, they basically came to the union and said, "Listen. We think we've found a loophole. If you like, take us to court. Go ahead. But you must realize that this could take 4 to 6 years and in the meantime what is going to happen to the pensioners? So you better negotiate with us." That's basically what they've done.

Since then, Colt has offered a buy out. They are taking advantage of the people's hardship once again, using it as leverage and offering them either lump-sum payments—which even at the best would only pay for roughly 6 years worth of medical coverage—or monthly sums at a fixed rate which would not even now pay for the medical coverage that they already have. And with the cost of medical coverage rising as it has been, it would cover even less as the years go by. Again, a company using the human factor and the hardship as leverage to get their own way.

I believe it's partially up to Congress to address this situation so as to assure your constituents that when companies make promises they will fulfill them. Some of the solutions that you mentioned earlier also have been on my mind and I think that the Congress needs to make sure that these promises are fulfilled.

Thank you very much.

[The prepared statement of Reverend Garner follows:]

PREPARED STATEMENT OF REV. MIKE GARNER, MIDLAND ALIVE COALITION, MIDLAND PA

My name is Reverend Mike Garner and I am here representing the Midland Alive Coalition (MAC), a citizens group which has been speaking out for almost two years on behalf of the people in the tri-state area (Ohio, Pennsylvania, West Virginia). We are faced now with one of the most far-reaching and potentially destructive situations we have yet encountered. Colt Industries, former owner of the Crucible Steel Mill in Midland, PA., is at this very moment attempting to drastically reduce or completely cut off the medical benefits of all former Crucible union employees now on pension. This will affect approximately 4,000 families.

The problem from a legal contractual standpoint is manifold and complex. From a personal and moral perspective, however, it is quite simple. Colt claims that it has found a loophole, a loophole large enough to let the lives of almost 8,500 persons slip through; men and women who, when they sat down face to face with Colt management for their final retirement interview were assured of the continuation of their health benefits for life!

It would be grave error on all our parts to allow this issue to be dealt with simply on the level of secret negotiations and or litigation, as Colt obviously desires. It would overshadow and minimize the more important personal and moral issues; i.e.

that Colt not only is attempting to break its promises, but also to destroy the lives of thousands of men, women and children who in no way can afford to make up the almost $250 per month of medical insurance that they would be losing.

THE MIDLAND ALIVE COALITION ANDY WHY IT IS INVOLVED IN THIS ISSUE

On November 30, 1983, 250 people jammed into a church auditorium to share with the MAC to share their concerns, struggles, and pain. Though their stories were different, their message was clear and spoken in one accord—"Stop Colt Industries from taking away the health benefits they promised to us for life!" The initial shock and disbelief of these Crucible pensionsers soon gave way to anger and open hostility. By early January 1984 over 1,000 pensioners, surviving spouses, and individuals representing pensioners too ill to attend came ready for action to a standing room only meeting sponsored by the MAC. They came united as a people who feel they have been lied to and pushed around long enough. Within one month, spurred on not only by the mandate but also by the feverish activity of these same people, the MAC staged a public campaign which almost single handedly forced a corporate giant to relent, albeit temporarily, in its efforts to condemn their former employees to an even bleaker future than they were already facing.

The MAC, a community based citizens action group, was organized the same day the death of the Crucible Steel Mill, by far the major source of employment and tax revenue in this small borough of 4,000, seemed to sound the death knell for our town and the surrounding tri-state area as well. Individuals from a broad range of religious, political, racial and socio-economic groups banded together to seek and implement ways in which economic stability could once again become a reality in our now devastated area. Such an alliance was a first for this community, traditionally split asunder by divergent heritage, ethnic origins and politics—and it has succeeded.

Our intention from the first regarding this pension benefits debacle has been to inform all segments of society—political representatives, industry, the medical profession and the public at large—of Colt's threats and strong arm tactics and the tremors which would be felt throughout the nation if they were even partially successful in their efforts.

Our testifying today before the Select Committee on Aging is one step in fulfilling our goal. But it must be remembered that we who are here today do not stand alone, but carry the testimony and the agony of almost 8500 people (pensioners, spouses and dependents), many of whose very lives depend upon the outcome of this fight.

MIDLAND, CRUCIBLE STEEL

The Crucible Steel Plant in Midland, Pa., was a fully integrated steel making facility—coking, melting in blast furnaces, open hearths, electric furnaces, top blown oxygen converters, fully integrated rolling reducing mills for slabs and bars, heat treating and finishing mills. It was a complete steel plant (See Appendix 1). In 1968, Colt Industries, a multi-national conglomerate and a smaller company, purchased Crucible Steel. In the next 14 years, the scenario unfolds where a smaller company liquidates the assets of the bigger company and transfers these assets to Colt and then shuts down the bigger company in 1982.

BIGGER NOT NECESSARILY BETTER

Colt's takeover was a death knell for the Crucible plant. In the early 1970's Colt was in serious financial distress. From 1968 to 1975, Colt transferred $137 million out of Crucible coffers to Colt. This action denied the Crucible plant the needed capital for repairs, replacement and new equipment. Colt's actions caused whole operating units to collapse: the open hearths, national drawn, DPC, iron foundry, Number 2 merchant mill, forge stock, vanport, coke plant and blast furnaces, to name a few. The management practices of Colt's top executives took no regard to the effect it would have on several thousand steelworkers in the tristate area which relied on Crucible for their sustenance. The Crucible plant produced a $125 million payroll per month and did approximately $25 million worth of business in its neighborhood. This figure excludes business done in the two major cities between which Crucible was situated, Pittsburgh, PA., and Youngstown, Ohio. The shutdown of the Midland plant created an economic hole as devastating as an atomic blast.

THE COLT ROLLER COASTER

During the winter of 1981-82 Colt and the United SteelWorkers of America entered into negotiations for a "giveback" on the contract by the union for the survival of the Crucible plant. In March 1982, the Union announced that it had come to an agreement with Colt. The very next day Colt announced that it was shutting down the plant. This was after several Colt initiated meetings in which Colt officials met with surrounding towns and promised them that the plant would never shut down. Subsequently, Universal Cyclops Corporation offered to purchase the plant for approximately $130 million. Cyclops negotiated a "giveback" agreement with USWA and announced they had come to terms (Appendix 2). The next day Colt announced it would not sell the plant to Cyclops. No reason ever has been given up to the present day for this change of mind. In addition, Colt refused to sell the mill to the employees. Later, J & L, a subsidiary of LTV corporation, purchased the plant for $8.1 million. It was rumored that over $7 million of finished steel inventory was left in the plant. If this is at all accurate, J & L purchased Crucible for relatively nothing. Colt received a $193 million tax write off on the Midland plant (Appendix 3).

During 1982, after the Crucible plant shutdown, company officials gave exit interviews to all Crucible employees explaining their contract benefits and ensuring the pensioners that they would be covered for life by the negotiated insurance agreement. In October of 1983, Colt sent the union a letter stating that they were going to terminate payment of the former employees insurance as of February 4, 1984. This matter was not publicly announced until November 30, 1983 at the Midland Alive Coalition meeting. Colt's conduct was a gross injustice to its former employees which were already suffering numerous hardships. With the loss of homes, cars, and other necessities many have been put into desperate straits. Colt's announcement on the insurance cut-off to their beleagured former employees shows the callous character of Colt who evidently considers their contract agreements promises to be broken.

The situation that was a catalyst for Colt's decision to shutdown the plant was the favorable treatment they received from the Federal Tax laws—$193 million tax write off to shutdown the plant and an additional $134 million to absorb the employee benefits costs. Certainly the tax laws are part and parcel of corporate decisions to shut plants down. A thorough review and perhaps revisions of these current laws are necessary for the protection of American workers from the actions of irresponsible corporations.

GOOD BUSINESS OR BAD BUSINESS

Colt's decision to cut off its former employees' insurance coverage would result in a long term gain for Colt estimated at approximately $250 million. Colt cannot lose. The real losers, in every aspect, are the former workers. Colt is relying on the hardship such an action would create for its former employees as leverage against the union in bargaining. Colt knows that a court case could conceivably take five to six years in order to resolve the dispute. There would possibly be an insurance blockout for hundreds to thousands of former employees who could not afford alternative coverage during the trial. Conceivably this could be the death sentence for those who would need serious medical attention and would not seek it because they could not afford it. During the court period, Colt could invest these monies and receive substantial profits from the interest. Even if they lose the court case, they have gained on these investments.

Recently Colt has announced that it would pursue an insurance buy out. Colt would offer a cash payment to individual pensioners of up to $20,000 exclusive of taxes to former employees as a settlement of their insurance obligation. This action is a punch below the belt, once again using the pensioners hardship as leverage, because Colt knows there are many out there who are in serious financial distress and would jump at the opportunity to receive such money to resolve their immediate needs and debts. It is estimated by the union that approximately 50% would accept such terms which could conceivably lead to a $100 million gain for Colt.

THE CRUCIBLE EMPLOYEES LACK OF BARGAINING POSITION

The Colt retirees are at a serious disadvantage and Colt is fully aware of this. The retirees actually have no bargaining position and they are at the mercy of the draculean appetite of Colt. The U.S. Supreme Court ruled several years in a case involving U.S. Steel Company that the USWA could not represent its retirees because

they are not due paying members. The USWA by law, however, is their only legal bargaining agent yet cannot represent these pensioners without Colt's consent.

Therefore the employees have no legal right to bargain as a whole with Colt. The result is that Colt can dictate terms with relative impunity to its former employees if it so desires. The seriousness of this employee disadvantage is reflected in this following example:

Mr. Robert Zielinski, Sr., is presently 82 years old and living with his wife, Mary who is 77. He is a diabetic and also suffers form hearing and eyesight loss as well as severe arthritis in his legs. His medical disabilities are job related and come from working on a steel floored hand mill which subjected him to extremes of noise and red hot steel affecting his eyes, hearings and legs. Mr. Zielinski retired from Crucible in 1965 after 38 years of service. He had never worked for Colt industries and so his contract benefits were secure at least so he thought. Though never an employee of Colt they now say they can cut off his insurance benefits. Mr. Zielinski contract expired years ago. The question is how can be bargin back his benefits. The answer is that he cannot. On top of this, at age 82 what are his chances of surviving a six year court battle without insurance benefits should he become ill. Certainly he will lose overnight everything he has worked for with a serious illness. Colt's actions are clearly intentional and criminal.

There are many other elderly retirees with the same prospects. Fear of the uncertainly of their future, in regard to their standard of living and possible medical costs, has put an arctic like chill on these already depressed former workers. An often heard remark by the elderly is "I have to have insurance but it will take much of my pension to pay for it and what will I have to live on." An example of this is Mrs. Eleanor Nevish who receives roughly $250 a month in pension and yet would pay out almost $200 a month for medical insurance. This is the prospect for the future. Substandard living, hardly a pleasant scenario for America the beautiful.

Who Are the Retirees: The Crucible retirees are the men at Normandy, Anzio, Caipan, Iwo, Chosin, Reservior, Inchon, and at Danang, Hue and Saign. When the whistle blew they answered the call then came home to pursue the American dream: a home, a car, a family provided for by a good job and, eventually, retiremant with dignity. For then the American dream has become a hollow dream. A nightmare created by Colt by its reneging on its social responsibilities and legal contracts. To regnege on such a commitment is immoral.

One of the residues of steel making is slag. Because it is not needed it is hauled to the dump. Can or should Colt or any other company deny its responsibilities to the human factor? Can Colt be allowed to dump the people who made Colt and this country as it once dumped slag? People whose lives are affected by a decision must be a part of the process of arriving at that decision. Crucible retirees are being dumped without any recourse.

The Federal tax structure of our country is such that it is more profitable for major corporations to go out of business than to sell the business. At least this is true in our case. Universal Cyclops Steel Corp. was almost the owner of Crucible Steel in Midland when Colt Industries unilaterally terminated the negotiations. Colt Industries later sold Crucible to LTV Corp. for a price far less than than that offered by Cyclops. Colt received a huge tax writeoff more valuable than the actual sale of the mill. Are our federal tax laws designed to reward the rich and wipe out the working class? When such policies are approved by the Supreme Court by our country we ask whether our government is of by and for the people or by and for the few wealthy corporations who value profit more than people.

Companies are in business to make a profit, nobody denies that. When companies value making even greater profits more than people, they terminate the jobs of those same dedicated workers who gave their sweat and blood to make the company succeed.

When jobs are eliminated on a wholesale basis as is being done in the steel industry, people are displaced from jobs in which they were skilled or for which they were trained with no immediate relief in sight. Their jobs are gone. There are not enough openings in the employment picture for them to get other work. The government's welfare system receives more applicants. The ranks of the poor increase and our countries greatest asset, its people, has been violated for the sake of excessive profits incorporate greed.

The United States has shown great care for distress people in other countries. The U.S. must show equal care for its own people by prohibiting a tax system that gives companies greater incentive to shut down operations rather than to employ people. Has the government reached the point of racing full speed ahead for the rich in letting the little guy be dammed? Can America and Americans afford corporations

like Colt, whose irresponsible actions result in the disruption of human life in the pursuit of profits without regard to the consequences? The Crucible Steelworkers have been witnesses to the crime of the century, i.e., a corporation that deliberately juggled its books and applied disreputible accounting methods to the detriment of the Midland plant. It closed the clasp on one of the best speciality steel plants in the world and probably the only one that is in full compliance with EPA standards. Colt's financial reports disclosed the fabulous salaries, bonuses, income tax loans and stock options enjoined by a callous management who took excellent care of itself to the detriment of thousands of people. The favorable tax laws certainly are a contributing factor. In addition, Colts lucrative contracts with the military are a further inducement to run away from competition and to finance operations supported by defense contracts and tax dollars where it is common knowledge that cost efficiency is not of primary importance. Certainly Congress should inspect Colt's questionable accounting methods which have been exposed by former Crucible Controller, Paul Schake.

If Congress acquiesces to corporations using the tax laws as an alternative for profits and allows corporations to renege on their contracted insurance program, what is the alternative for American workers? It is foreseeable that the alternative could be national health insurance. The corporations would then have succeeded in cost shifting their obligations to the Federal Government and therefore back on to the taxpayers. Colt fancies itself as "the gun that won the west." It is the same "Colt" that assassinated Midland Crucible, and is presently trying to shoot its employees out of the saddle on their insurance benefits. Colt obviously thinks its contracts are to be treated as promises that can be broken.

CRUCIBLE INC
DIVISION OF COLT INDUSTRIES

Located on the North Bank of the Ohio River at Midland, Pennsylvania, thirty-four miles northwest of Pittsburgh, the Crucible Alloy Division and the Crucible Stainless Steel Division of Colt Industries employ a work force numbering upwards of five thousand men and women.

Known throughout the Beaver Valley as simply "Crucible", these two divisions of Colt Industries take their name from the method by which fine tool and alloy steels were made until after the turn of this century. The method, called Crucible Melting, was invented in 1740 in Sheffield, England. Iron, selected scrap and various alloy elements such as nickel, silicon, manganese and chromium were measured into small crucible pots. The pots were capped and placed side by side in a furnace pit where the metals were fused and melted into steel. Then a very strong man called a "teemer" gripped the crucible vessel with tongs and in a continuing motion, poured the metal into one hundred pound ingots.

In 1900, the formation of Crucible Steel Company of America united the largest and best crucible process steel plants in the country. Its craftsmen practiced all the known arts of melting, heat treating and working alloy, tool and other specialty steels.

The Midland Works of the Crucible Steel Company of America was originally the property and the works of the Midland Steel Company. Through this purchase, the company acquired the facilities and plants to supply steel to its various specialty steel operations throughout the country and to its thousands of customers.

Over the years, under Crucible and later Colt Industries, the original Midland Plant has been expanded and improved until it now comprises a completely integrated unit for the production of a wide range of high quality alloy, specialty and stainless steel products. It is the largest producing facility for stainless steel sheet and strip in the country--perhaps in the world.

The Crucible Steel Divisions of Colt Industries today employ the most modern melting, refining, casting and rolling techniques. The two Colt Divisions at Midland are major suppliers to the automotive, chemical process, mining, power, forging, off-highway transportation, appliance, food processing, mass transit, and general metalworking industries in the United States.

CYCLOPS
650 WASHINGTON ROAD PITTSBURGH PENNSYLVANIA 15228

JAMES F. WILL
EXECUTIVE VICE PRESIDENT
STEEL OPERATIONS

June 23, 1982

To: The Employees of Midland

As you are aware, Cyclops Corporation is trying to buy Crucible's Midland facility. Cyclops Corporation is a company proud of its record in the steel industry, a record which also began almost three quarters of a century ago. Last year, 70% of our sales volume, almost $750 million, was attributable to our steel operations, which now employ about 5,500 people.

While Cyclops is a big company, we are not large enough to absorb the near-term losses while spending the capital required to improve the facilities. The long-term success of Midland depends on major improvements in productivity encouraged by a new spirit of cooperation.

In preliminary discussions with your representatives, we have addressed these issues. Your leaders will be talking to you about our discussions and the solutions we recommend. With your support and a new relationship with Cyclops, we believe that the Midland facility can return to its historic position as a proud and profitable producer of specialty steel.

Sincerely,

J.F. Will

MAY 3, 1984

"WHAT'S GOING ON?"

In a recent interview with the Washington Post, a spokesman for Colt Industries stated that some pensioners were promised health benefits for life by Colt exit interviewers, but that they shouldn't have been. How well does this statement line up with the facts?

1) Colt used its top Crucible management personnel as exit interviewers.

2) These individuals were trained for one week or more, and some of those doing the interviewing actually were responsible for training other interviewers, so they would have to have been very knowleadgeable on the desires and instructions of Colt officials).

3) Each interviewer was given a manual explaining all of the necessary points which each pensioner would need to know.

4) These officials knew that union personel would be present at all interviews to question and note any false information or improprieties.

5) Used Pre-Retirement Information Forms in each interview, one major point of which (there were only five) dealt specifically with the the health benefits issue.

6) Each interviewer knew that this issue in particular would be of major concern to each pensioner; (and in fact we have signed statements which tell us that some pensioners asked about this issue three or four times during their exit interview).

7) These interviews were conducted over a period of several months, plenty of time to correct any errors or misunderstandings.

IN ADDITION:

8) Colt officials were well aware of the fact that the 1977 Steel Settlement between all major steel industries very specifically dealt with the issue of health benefits for life--and this being in the context of plant closings!

9) Never once before September 1983 shared any intention or information with pensioners, management or stockholders which would indicate a cut-off date, even though a time period of over one

year elapsed between the final exit interview and Colt's surprise announcement.

And yet, even after considering all this contrary evidence, stockholders and pensioners alike are expected to accept a statement that such promises should never have occured???

It seems that only one of two (or perhaps both) conclusions can be reached:

A) Colt officials have not been telling the truth; or,

B) This corporation is being run more inefficiently and irresponsibly than anyone could ever have believed a major corporation could be!

The Midland Alive Coalition comes here not only representing a group of 8,500 people who will be left in terrible financial and physical straits if this corporation does not hold up to its full responsibility of lifetime health benefits for all pensioners, spouses and dependents of Crucible Steel, but also representing concerned stockholders who believe this company's policies not only to be morally and socially inexcusable, but professionally and financially unsound as well!!!

"WHAT'S GOING ON?"

CONTACT: REV. MICHAEL C. GARNER
PRESIDENT, MIDLAND
ALIVE COALITION
907 VIRGINIA AVE.
MIDLAND, PA 15059
412-643-4406/643-8880

John Heinz
Pennsylvania

United States Senate

Committees:
Aging
Finance
Banking, Housing and Urban Affairs
Energy and Natural Resources

Washington, D.C. 20510

January 18, 1984

Mr. George Strichman
Colt Industries
Chairman, CEO
430 Park Avenue
New York, NY 10022

Dear Mr. Strichman:

Reports that Colt Industries plans to terminate health insurance benefits for its retirees from the former Crucible Steel facility at Midland, Pennsylvania, are, at the very least, distressing.

Furthermore, the motivation behind this plan is difficult to comprehend in light of your former employees' reliance on promises that their pensions and health benefits would be assured for life, promises made by representatives of Colt Industries to retiring workers on both individual and collective bases.

My interest in the security and welfare of past and present Crucible workers at Midland has not abated since the sale of the plant. Insofar as I am able, I remain determined to use my office to assure that their interests are protected against unfair and unwarranted attrition.

Therefore, I urge you to reconsider this matter. Notwithstanding the legal niceties of the situation, your former employees have relied in good faith on company promises.

In my view, corporate responsibility is at issue. The extent to which Colt Industries acknowledges its obligations in this situation will speak volumes regarding the basis under which Colt Industries is prepared to do future business--with its employees and retirees, with other companies, and with government.

Furthermore, it is not too much to say that many others will be watching for the result of this unfortunate situation as a means of gauging Colt Industries' future intentions.

Once again, I urge that health insurance benefits be reinstated for Crucible retirees. To do otherwise may impose on the retirees, affected communities, and even Colt Industries prohibitive burdens in the future.

Sincerely,

John Heinz
United States Senate

Midland Alive Coalition

INGREDIENTS PLAYING A FACTOR IN THIS ISSUE:

1) The demise of the Steel Industry and the devestating effect it is having upon people and the areas they live in.

2) Big business vs. the little people (which ties into the mentality of the Reagan administration and its policies). Especially pertinent is the fact that it is a large conglomerate which is totally detached from the lives of its former employees.

3) Staunch union supporters who have given their 100% backing to the union for decades are now turning against it. Their antagonism has reached a point where they even speak of suits and/or violence.

4) Cyclops, another steel corporation, originally offered to buy the Crucible mill for approximately $170 million, but was turned down by Colt. J&L's buying price? $8 million!

5) Colt Industries took over $230 million in tax write-offs when they closed the mill on Oct. 15, 1982, $134.1 million of that specifically for employees' benefits. Now they say they are not going to pay. Is this corporate double-dipping?

6) Colt management told over 4,000 men and women who were retiring that they could be assured of continued health benefits for life for them, their spouses and their dependents during exit interviews. Now they say "No go!"

7) There is a possibility because of a Supreme Court ruling in the favor of US Steel in a previous case that pensioners have no one to bargain for them legally. The decision handed down basically stated that, since retirees were no longer dues paying members of the union, it could no longer represent them. Where does that leave them?

8) People such as our retirees have no power or weapons in the traditional sense to fight such actions (e.g., strikes, etc.). Again, where does that leave them?

9) This has all the markings of a test-case. What happens here could have national ramifications if others decide to try such a stunt.

10) Colt really has nothing to lose. There are 3 alternative endings: a) Compromise--Colt gains some; b) Colt wins lawsuit--Colt gains a lot; c) Colt loses lawsuit--Because they would only be responsible to repay all medical costs to pensioners during the time the matter was in court, and those costs would assuredly be lower than the premiums for those years, again Colt gains some. They have it made!

11) The possibility of a union mess-up on the original contract.

Midland Alive Coalition

COMMENTS GLEANED FROM RESPONSES
TO INCOME SURVEY

**In response to question regarding how much they could pay each month for medical benefits:

"We have nothing left over and can hardly make it now."

"It takes most all our money to meet the rising cost of utilities."

"None--could you on these wages?"

"No more than we are paying."

**General Comments:

"My wife and I are both heart patients. I gave 36 years to that place."

"I have glaucoma of my left eye caused as a result of an injury sustained at the mill." ($20/month or more for life)

"I have cancer -- $860 every three weeks for treatment."

"I had cancer and have to have checkups. I had a heart attack in 1974."

"I have high blood pressure and my wife has had five heart attacks."

"I had one heart operation and will need another soon. I have hypertension."

Midland, PA 15059

Midland Alive Coalition

STATISTICS REGARDING PENSIONERS
AFFECTED BY COLT'S INTENTIONS TO REDUCE
OR DISCONTINUE HEALTH BENEFITS

Estimated number of people affected:	4,118 pensioners 3,168 spouses 1,180 dependents 8,466	
Age breakdown:	Under 65 - 53% Over 65 - 47%	This means up to 53% of these people will not have any medical coverage as of Feb. 4

(Source for above statistics: Blue Cross/Blue Shield of Pennsylvania)

INCOME SURVEY RESULTS
(Total respondents - 182)

ASSETS

-Without any savings -- 104 (57%)

-Homeowners -- 123 (68%)

-Still paying mortgage -- 49 (27% of total respondents; 40% of homeowners)

INCOME

-Behind in their bills -- 32 (18%)
-"Not yet" behind, but very near -- 9 (5%)

PENSIONERS' ESTIMATES OF WHAT THEY CAN PAY FOR MEDICAL INSURANCE

Amount	Number	Percentage
$0	57	66%
$1-25	8	9%
$26-50	9	10%
$51-75	3	4%
$76-100	8	9%
$100-	2	2%
TOTALS	87	100%

Midland, PA 15059

Rev. 8/82

PRE-RETIREMENT INFORMATION FORM

Type of Pension: 80 Comb

Name	Check No.	Date
Richard H Simmons	70294	4/1/83

Address	Zip Code	Social Security No.
46716 Silver Hill Rd Fox Lusyon OH	44120	283-24-6024

1. PENSION - The information in this section is not to be considered binding until it has been checked and approved by the Pension Board. You will be provided with an official calculation of your pension benefit at a later date.

AGE 53 BIRTH DATE 2/6/30 LENGTH OF CONT. SERVICE 29 yrs

CONTINUOUS SERVICE DATE 8/26/63 DATE LAST WORKED 6/23/83

EFFECTIVE DATE OF PENSION May 1 1983

You are eligible to receive 9 weeks of special retirement pay about the first week of June 1983. Your first monthly pension payment will be for the month of August 1983 and you should receive it about the first week of September 1983.

2. LIFE INSURANCE - Basic Life Insurance and Optional Insurance (if you were covered on your last day of work) is continued to age 62 at no cost to the retiree. Upon attainment of age 62, the Basic Life as well as the Optional Insurance are both cancelled. The Retiree then becomes eligible for an interest of $1,500 in the Crucible Death Benefit Fund without further contribution. This amount is payable only in the event of death. If you are over 62 years of age, and if you so choose, you can convert a part of this difference in coverage to an individual type policy. The approximate annual cost per $1,000 will be $ 52.26 . Application, however, must be made either within 31 days following date of retirement or 31 days after attaining age 62.

3. BLUE CROSS & BLUE SHIELD - HOSPITAL AND MEDICAL BENEFITS - If your Group Hospitalization was in effect immediately prior to the date you applied for a pension, you have the privilege to convert this coverage, at no cost, under the Associated Group Program for Steel Retirees. Major Medical coverage may be continued at an additional premium.

4. SOCIAL SECURITY BENEFITS - MEDICARE BENEFITS - If you have not already done so, you should visit your nearest Social Security Office and make application for your Social Security Benefits and Medicare Benefits. Be sure to have your Social Security Card and proof of Age with you.

Extended Vacation Benefits due under the Savings & Vacation Plan are separate from the Pension Agreement and will be paid as an additional benefit shortly after retirement.

If you have any questions or need assistance pertaining to the Insurance Conversion or the Pension Program, please do not hesitate to call or visit us at your convenience.

I am aware that I can apply for age/service pension or pension based on disability.

I elect disability pension _____ Signature

I elect age/service pension Richard H Simmons Signature

CRUCIBLE INC - P. O. Box 226, Midland, PA 15059 PHONE: 412/643-1100

Paul K. Schake vs. Colt Ind

IN THE US. DISTRICT CT. FOR THE WESTERN DISTRICT OF PA

Civil Action 81 251 C.D. 251

AFFIDAVIT OF PAUL K. SCHAKE

been lost had I attempted to defer my departure date from Crucible. Similar considerations determined the termination dates of plaintiffs Henglein and Frank.

38. Prior to terminating my employment with Crucible, I made arrangements to assure that trained personnel would be available to perform the very limited and relatively insignificant duties that would have been assigned to me subsequent to October 1, 1982. Similar arrangements were made in the case of plaintiffs Henglein and Frank. As a result, defendants suffered no disruption or loss by reason of the inability of myself, Henglein and Frank to serve out the periods of time set forth in the various Continuance Agreements. I do not claim, and plaintiffs Henglein and Frank do not claim, entitlement to the "accrued continuance bonus" set forth in the various " Continuance Agreements" which we signed. We claim only severance pay.

Colt's Disregard of the Corporate Identity of Crucible.

39. Throughout the 14-year period from 1968 to 1982, that Colt owned all of the stock either of Crucible, Inc., or of Cru-Colt, it disregarded the separate corporate status of such entities. The officers and managers of Colt assumed and directly exercised all authority and responsibility for decision making on all questions arising from the operation of such entities which related to the possible generation of "profits", real or imagined. This was done with the fundamental, overriding purpose of forcing the management people running the Midland plant to subordinate all concern for the financial, physical and long term needs of Midland to the creation

of a largely fake image of Colt as an extremely efficient and highly profitable organization. The pressures for such subordination were particularly severe during periods in which the possibility existed for the sale of Colt stock at a substantial premium above market value as was true during 1981 when a possible consolidation of Colt with Penn-Central was being considered.

40. Crucible managers were ordered, not by the board of directors or senior officers of Crucible, but directly by senior operating officials of Colt, to delay investment of profits generated by Crucible facilities in essential producing facilities which, lacking such critical investment, thereafter collapsed or otherwise became unproductive in any economical sense.

41. The officials of Crucible were repeatedly ordered, again not by the senior officers of Crucible or by the board of directors of Crucible, but by the officials of Colt, to: misrepresent expenditures which were in the nature of expenses as capital expenditures; to misrepresent receipts, which should have been classified as a return of capital, as profit; to generate income by reversing all available reserves; and to claim tax credits for alleged research and development outlays which were nothing but standard equipment purchases.

42. In order to demonstrate with precision the extent to which Colt preempted the proper functioning of the entity operating the Midland Plant, and the extent to which in so doing it violated standard accounting procedures and Internal Revenue Service regulations, I would require an opportu-

39-353 O - 85 -3

nity to review Colt's accounting files and its correspondence with Arthur Andersen and Company, Colt 's accountants.

Colt's Destruction of the Midland Plant

43. In 1968 the Midland Plant and the other facilities of Crucible Steel were functioning effectively. The product mix of stainless and alloy steels gave the company a far brighter future than that enjoyed by carbon steel mills. The facilities were well maintained, substantial reserves were set aside for the replacing of aging plant components, and a concern for quality and customer service characterized the entire company.

44. With the Colt takeover a concern for the image of Colt, and of how the Midland Plant could add to that image by inflating the apparent earnings of Colt, became dominant. Facilities were allowed to deteriorate to the point of collapse - as in the case of the coke plant and the blast furnace, the plant's most important facilities - without the infusion of maintenance funds or of reserves for eventual replacement, which were siphoned off to Colt. From 1969 through 1975 about $137,000,000 was taken out of Crucible by Colt. the Plant's production capacity declined steadily with the removal from service of such essential facilities as the blast furnace. Costs per unit of output thus steadily increased. The efficiency of plant components still in use progressively declined as such components were denied the benefits of new equipment and advances in technology. Cost cutting drives intended primarily to increase the flow of earnings to Colt were carried on with such pressure as to encourage the rationalization that maintenance and plant upgrading

could always be deferred.

45. Under pressure by Colt for the generation and the transmission to it of profits, price gouging of customers and indifference to customer complaints concerning quality became typical during periods of high sales volume, but with readily predictable, and severe consequences during periods of sales decline.

46. I am confident that I will be able to fully substantiate in detail all of the above statements if I am given the opportunity to review in depth the files of Colt as they relate to its operation of the Crucible facilities, and if I am given access to the accounting records of Colt which concern the day to day efforts by Colt officials to alter and adjust the apparent profits of Colt through the altering and modification of the financial and accounting reports submitted in the name of Crucible as a supposedly distinct entity.

Paul K. Schake

PAUL K. SCHAKE
plaintiff

Subscribed and sworn to
before me this 19 day
of April, 1984.

Sabina M. Kraus
Notary Public

MY COMMISION EXPIRES: Nov. 17, 1986

Most severely affected by the continuing recession in 1982 were our Quincy compressors, Crucible magnets, Pratt & Whitney and Elox production equipment, Fairbanks Morse pumps, Crucible specialty steels, Garlock packings, and Colt firearms.

A number of our divisions to which replacement parts markets are important were affected as reduced equipment usage and the stretchout of repair and maintenance programs in customer industries resulted in sharply lower aftermarket demand. This characteristic of the current recession was not evident in prior recessions. Despite the recession, many of our divisions held or increased market share.

Although capital expenditures were down in 1982, the company continued an aggressive plant and equipment improvement program. The Crucible Specialty Metals Division continued the multi-year modernization of its billet conditioning facilities; the Holley Replacement Parts Division opened a plant in Springfield, Tennessee for the production of LPG fuel systems and the remanufacture of replacement carburetors; and several divisions added to their production capabilities.

Product Developments

Emphasis continued during the year on the development of new products and processes. The Chandler Evans Control Systems Division is developing a full-authority digital electronic fuel control system, Pratt & Whitney introduced a large Wolverine horizontal spindle die-sinking machine, and Elox introduced several electrical discharge machining (EDM) products.

Quincy Compressor Division developed a new oil-free-air compressor. The Menasco Texas Division completed production of main and nose landing gear for the F-16E prototype aircraft and the main landing gear for the X-29 testbed aircraft.

Other new products included the Fairbanks Graphic 7 electronic scale, Trent finned heat-exchanger tubing, and a new line of Fairbanks Morse split-case horizontal pumps for industrial use. Emphasis at the Crucible Research Center was on titanium alloys and near net shapes for aircraft engine and artillery components and for prosthetic devices used as human joint implants. Garlock Mechanical Packing Division added to its line of Blue-Gard® nonasbestos gasketing materials.

Midland Disposition

On March 10, 1982, the company announced the decision to dispose of its Crucible Stainless and Alloy Division in Midland; and, on August 17, 1982, the company announced the decision to close the Midland facility permanently. On November 24, 1982, the company announced the signing of an agreement for the purchase of the Midland facility by Jones & Laughlin, a unit of LTV Corporation. The sale, subject to review by the U.S. Department of Justice and to closing conditions, is expected to be completed early in 1983.

In the first quarter of 1982, an after-tax provision of $39.4 million was made against earnings to cover forecasted operating losses at the division from April 4, 1982 through final disposition. In the second quarter of 1982, an additional after-tax provision of $193.0 million was made against earnings to cover the estimated costs of shutdown and disposition of the facility. This net provision was made to cover the assets writedown of $47.6 million to their estimated realizable value, employee benefit costs of $134.1 million at present value, and other related costs of $11.3 million. In our opinion, based on currently available information, these provisions are reasonable estimates of the costs associated with the decision to dispose of the division. Actual costs may vary from the estimates; and the provisions could, therefore, require future adjustments.

During the year, the company purchased 3.3 million shares of its common stock, bringing our purchases since the program began in 1979 to a total of 4.7 million shares, or 17 percent of shares issued. These stock purchases, conducted under a Board authorization totaling eight million shares, have helped to bring the shareholders' equity into better balance with the lower level of company sales. During 1982, the company paid record dividends totaling $44.8 million. The per share dividend in 1982 was $1.80, up 17 percent over 1981.

There are no present signs that the recession, as it affects our markets, has ended. But the decision to dispose of the Midland facility is behind us, with provision made to cover its costs; and our attention is now sharply focused on our continuing operations. This, coupled with our considerable financial strengths and strengths in markets served, is the basis for our confidence in the long-term future of Colt Industries and in the company's ability to benefit from an improving national economy and an increase in demand for the industrial products we make.

George A. Strichman
Chairman of the Board

David I. Margolis
President

January 27, 1983

See p. 22
United Steelworkers of America
Steel
Settlement

EMPLOYMENT AND INCOME SECURITY PROGRAM and OTHER BENEFIT IMPROVEMENTS

38

INTRODUCTION

In the following pages a full explanation is provided of the new Employment and Income Security Program and the many other changes and improvements negotiated in the benefits section of the new Agreement. Increased pensions have been negotiated for employees who retire after July 31 of this year. The pension supplement is increased for those who are forced to retire early because of disability, layoff, or plant shutdown. The pension cap is substantially liberalized. Pensions for past retirees and spouses are improved. The medical program for past and future retirees is improved.

A new holiday has been added to the Agreement. A completely new program of vision care is contained in the new Agreement, providing substantial benefits for employees and dependents who wear glasses.

The weekly benefit maximums for SUB are increased 25%, SUB funding is substantially increased, and significant other improvements are made in the SUB section.

Substantial increases are provided in the sickness and accident benefits, major medical and other insurance plans, life insurance, and other benefits.

To eliminate confusion between the special benefits of the Employment and Income Security Program and the other benefit improvements for all employees, those which apply only to the new Program are described on the pages colored grey, immediately hereafter.

I. EMPLOYMENT AND INCOME SECURITY PROGRAM

Our Union has achieved a significant and far-reaching advance in job security in the 1977 Agreement. This new benefit, unprecedented in American industry, is a unique pension called "The Rule of 65." It forms the foundation for the Union's Employment and Income Security Program.

The new Employment and Income Security Program contained in the 1977 Agreement is designed specifically to meet the particular concerns and problems that confront the employees in the basic steel industry. The greatest fear that haunts steelworkers employed in an old plant is that the plant may be closed entirely, or one or more departments may be closed within the plant.

The Rule of 65 pension (20 years or more service plus age) will permit eligible employees affected by plant shutdown, extended layoff or disability to retire on a regular pension plus a $300 supplement.

The Rule of 65 pension and pension supplement, and the related programs contained in the new contract would impose an extremely

34

avy financial obligation on a company for the shutdown of an old facility. It is intended to encourage companies to take the other option—and use the money to modernize the old plant. To the extent it accomplishes this goal it will protect the jobs of young and old alike.

The second major fear of every steelworker is the fear of long term sickness or disability. Long term sickness and disability rob the worker and his family of savings, and may pile up debts which can never be paid. The new Employment and Income Security Program deals with this human catastrophe, as well as the problems of plant shutdown and long term layoff.

Delegates to the 1977 Steel Industry Conference set as one of their highest priorities the establishment of a lifetime security program for employees in the steel industry. This history-making demand will rank with the demands thirty years ago for fully-paid medical and hospital insurance and non-contributory pensions as a major new concept in collective bargaining. Not only steelworkers, but all other industrial workers who follow the patterns we achieve will benefit.

Like our present-day pension and insurance programs, however, the cost of this long-range objective is far too great to be overcome in any one round of bargaining. The bare foundations of the pension and insurance programs were laid in the 1950 contract. Each negotiation thereafter built on that foundation, until we achieved our goals.

Similarly, we have laid the foundation in this 1977 contract on which to build a lifetime security program for all steelworkers. This foundation consists of a series of greatly expanded benefits for 40% of the employees of the ten major steel companies—those with 20 or more years of service. In future negotiations we must increase the group of employees covered by the plan until all are protected. At the same time, we must work to increase the benefits provided by the plan until it fully meets the goal of lifetime job security.

Even today, most employees who work in American industry are highly vulnerable to economic disaster if their plant closes or in the event of a prolonged layoff or disability.

For the past three decades, the Steelworkers Union has consistently worked to develop, through the pension, SUB and other benefit programs, a means of cuthioning the impact of job instability. No other union has done as much to promote income security. For example, as long ago as the 1960's, the pension program in the steel industry included the so-called 70/80 "magic number" formula which provides both immediate pension and monthly supplemental benefits to older employees who were involuntarily displaced from their jobs. Since 1965, we have had a thirty and out pension option.

In achieving the Employment and Income Security Program, the Union chose to build upon and expand those programs which have served us well over the years. Not only has the level of income protection been raised and strengthened, but, equally important, the scope of coverage has been expanded to include younger workers who also need protection against economic uncertainty.

The important breakthroughs of this foundation for the New Employment and Income Security Program must not be underestimated. Now, more than ever, the steel companies must take into account, in making their financial plans, the enormous human costs of their decisions to close some departments and some plants and to open others at new locations. These decisions had always been made, in the final analysis, only on a profit and loss basis—profits or losses to the company involved. The financial losses to and the human tragedies inflicted on middle age Steelworkers have never been seriously considered by the companies.

The new Employment and Income Security Program creates a dramatic new protection for the group of workers in their 40's and 50's who need it most. As explained in the Program, a worker whose plant closes when he is only 41 years of age and has only 20 years of service will be entitled to up to two full years of supplemental unemployment benefits, and thereafter a Rule of 65 pension and pension supplement totaling a minimum of over $580.00.

The cost of this new protection is not limited by prior SUB planning. It is a massive obligation on the corporate treasury which company executives will have to consider when they make their long range plans.

The new Rule of 65 pension program will not replace in any way the pension benefits under the 70/80 "magic number" pension program of the old contract. The eligibility rules of that program will continue in effect for those who meet the age and service requirements of the 70/80 formulas.

Highlights of other benefits in the new Program are:

- SUB Benefits extended an additional 52 weeks.
- Guarantee of all SUB weekly benefits, regardless of financial level of the SUB Fund.
- Increase in Short Week Benefits.
- Short Week Benefit Guaranteed.
- Increase the level of base earnings protected by the Earnings Protection Plan to 90%.
- Earnings Protection benefits guaranteed.
- Up to an additional 52 weeks of Sickness and Accident benefits.
- Insurance coverage continued during extended SUB or S&A.

Each of the benefits of the new Employment and Income Security Program is described in the following pages. These benefits will become effective January 1, 1978, for the employees covered by the new program.

A. Rule of 65 Pensions—$300 Supplement

The United Steelworkers of America has always pioneered in the negotiation of pension benefits, winning "30 and out" long before other unions; developing "magic number" or "70/80" pensions. Only Steelworkers receive a 13-week special payment upon retirement. The 1977 Settlement again establishes a first for union contracts—the "Rule of 65" pension option which is the foundation of our Employment and Income Security Program.

Effective January 1, 1978, an employee with 20 or more years of service as of his last day worked becomes eligible for a Rule of 65 pension if (1) he is off work because of a shutdown, extended layoff or disability, (2) his age plus service equals 65 or more, and (3) his company fails to provide him with suitable long term employment. Because he accrues age and service during layoff or sickness (commonly called "creeping"), a twenty-year employee who meets all of the requirements need be *only 41 years old* when first laid off, or when his Sickness and Accident Benefits begin, to become eligible for a Rule of 65 pension.

The amount of pension is calculated as it is for other pensions. However, in addition to the pension amount, a Rule of 65 pensioner also draws the pension supplement which has been raised by the 1977 Settlement to $300 per month. This supplement is suspended should the retiree obtain suitable long term employment, but it is resumed if such other employment ends. Otherwise, the supplement continues until age 62 or such earlier time as the retiree becomes eligible for Social Security.

B. SUB Benefits Extended 52 Weeks and Guaranteed

Increases in maximum benefit and other improvements in Supplemental Unemployment Benefits apply generally. They are described on pages 33-34 of this explanation. In this section, we describe only the special protections which are part of Employment and Income Security Program benefits for employees with 20 or more years of service.

1. *Extended Weekly Benefits*—Currently, the maximum duration of benefits is 52 weeks. Effective January 1, 1978, however, that period will be extended by an additional 52 weeks. While the conditions of

SUB eligibility for the first 52 weeks are not changed, extended SUB benefits continue during the second 52 weeks of layoff so long as the employee is not offered appropriate work at his home plant or suitable long-term employment at other locations. Additionally, in the case of an employee affected by a plant shutdown, eligibility for benefits during the period of extended SUB (the second 52 weeks) ends if and when the employee becomes eligible for an unreduced immediate pension.

The precise guidelines and standards for determining what is "appropriate" or "suitable" work will be hammered out in the near future by the Employment and Income Security Task Force (see discussion on page 25). However, it is evident that for purposes of maintaining SUB eligibility, laborers' jobs will not be considered "appropriate" for skilled workers such as craftsmen. Similarly, a job requiring a *long distance* move to another plant will not be considered "suitable" for employees affected by a shutdown of their home plant.

One other important point is that although the new program does not go into effect until January 1, 1978, it covers employees who were laid off before that date. This means, for example, that a covered employee who was laid off this year will be eligible for an additional 52 weeks of SUB benefits after next January 1.

2. *Guarantee*—The new Program insures payment of SUB for covered employees. In the past, SUB benefits were subject to the financial position of the Fund. They could be reduced, therefore, or even eliminated when the Fund sank to low levels. Fortunately, this did not occur very often, but it did happen in some companies during the term of the current Agreement. Now, as part of the Employment and Income Security Program, the weekly benefit is guaranteed for covered employees. This guarantee applies to the first 52 weeks as well as the extended period. Accordingly, after January 1, 1978, weekly benefits for covered employees will still be paid out of the SUB Fund, but they will not be subject to reduction or elimination because the financial position of the Fund sinks too low. Instead, in such cases, the Company will advance money to the Fund to cover the cost of these benefits. The advance can be recovered later, but such recovery cannot operate to reduce weekly benefits paid to more junior employees.

C. Increased Short Week Benefits—Guaranteed

Short week benefits have in the past been calculated on the basis of the employee's standard hourly wage rate. Under the new Employment and Income Security Program, the short week benefit for covered employees will be calculated on the basis of average straight-time hourly

earnings, just as the weekly SUB benefit is now calculated. This means that incentive earnings and shift premiums will be included in the benefit calculation, thereby raising the short week benefit to substantially higher levels for virtually all incentive workers.

As in the case of SUB weekly benefits, short week benefits have been subject to the financial position of the Fund. Under the new Program, however, short week benefits will be guaranteed for covered employees in precisely the same way as weekly SUB benefits will be guaranteed.

D. Earnings Protection Plan Improvements

The Employment and Income Security Program makes two important improvements in the Earnings Protection Plan, for covered employees.

First, the protected level of hourly earnings is raised from 85% to 90% of the base period rate.

Second, the "base period" itself is modified. It can be the calendar year preceding the benefit quarter, as it now is, or it can be the calendar year next before that, whichever of the two years results in a higher base period rate. This change promises to further increase the benefit for many employees.

E. Extended Sickness and Accident Benefits

Covered Employees temporarily disabled (but not permanently incapacitated) by sickness or accident will become eligible for up to an additional 52 weeks of Sickness and Accident benefits (S&A) under the new Program. This makes the total benefit duration 104 weeks. Moreover, even though they became disabled prior to the January 1, 1978 effective date of the Employment and Income Security Program, covered employees on disability will still become eligible for the extended S&A benefits. These changes are in addition to the higher benefit rates described on page 35.

F. Extended Insurance Coverage

All insurance coverage except S&A benefits is now continued during the first 52 weeks of SUB benefits. Under the Employment and Income Security Program such coverage will now be continued during the period of extended SUB benefits (an additional 52 weeks) for covered employees. Similarly, all insurance coverage will be continued while covered employees are receiving the extended S&A benefits described in the preceding paragraph. This means that these employees will receive up to 104 weeks of insurance coverage while they are disabled or laid off. Finally, notwithstanding the January 1, 1978 effective date

for the Employment and Income Security Program, eligible employees laid off or disabled prior to that date will still qualify for continued insurance coverage and their coverage will continue so long as extended benefits are being received.

G. Employment and Income Security Task Force

On May 1, 1977, an Employment and Income Security Task Force will be established consisting of an equal number of high level Union and Coordinating Committee Steel Company representatives. The Task Force's first mission will be to develop guidelines for operation of the Rule of 65 pension and the extended benefits provisions of the SUB Plan. Thereafter, it will make a thorough study of all the elements necessary to increase employment opportunities in the steel industry and expand the Employment and Income Security Program introduced by the 1977 Settlement into a broader-based lifetime security program. The Task Force is to complete its work not later than November 1, 1979 in order that this matter may be fully and intensively addressed during the 1980 round of negotiations.

II. HOLIDAYS

The new Agreement provides for a new holiday, United Nations Day. Though this holiday actually falls on October 24th, it will be observed under our contract on the fourth Monday in October when it goes into effect in 1979. This brings the holiday total in the Agreement to eleven.

III. PROGRAM OF VISION CARE

One highlight of the 1977 Settlement Agreement is a new program of vision care insurance. Beginning August 1, 1979, employees and their eligible dependents will be covered by a vision care plan paid for entirely by the company. The program will cover the following benefits:

1. The actual charge, up to $20, of a vision examination once every 24 months.

2. The actual charge, for two lenses (once every 24 months) up to certain maximums which vary with the type of lens. The maximums are $10 for a single vision lens, $15 for a bifocal lens, $20 for a trifocal lens, $25 for a lenticular lens, and $15 for a contact lens.

3. The actual charge, up to $14, for eye glass frames once every 24 months.

New lenses will not be covered unless the prescription differs from the most recent one by a prescribed measurement designed to insure

PROGRAM OF HOSPITAL-MEDICAL BENEFITS For Eligible Pensioners And Surviving Spouses

See p. 1

of

Colt Industries
CRUCIBLE INC

Pursuant to Agreement With
UNITED STEELWORKERS OF AMERICA

Effective January 1, 1981

FOREWORD

This booklet is the summary plan description required by the Employee Retirement Income Security Act of 1974 (ERISA) of the Program of Hospital-Medical Benefits which has been established pursuant to the Pensioners' and Surviving Spouses' Health Insurance Agreement dated January 1, 1981, between Colt Industries, Crucible Inc and United Steelworkers of America. This booklet is applicable to employees of Colt Industries, Crucible Inc (hereafter, "Company"), whose headquarters are located at 430 Park Avenue, New York, NY 10022, represented by the United Steelworkers of America (hereafter, "Union"), whose headquarters are located at Five Gateway Center, Pittsburgh, Pennsylvania 15222. This booklet constitutes a part of The Pensioners' and Surviving Spouses' Health Insurance Agreement, which continues until December 31, 1983 and thereafter, subject to negotiations between the Company and the Union which may take place no earlier than 1983.

Details relating to the operation of the Program will be included in reasonable rules, regulations and arrangements with insurance carriers.

The hospital and physicians' services benefits of this Program, which are paid for entirely by the Company, are provided in accordance with agreements entered into by Colt Industries, Crucible Inc with Blue Cross and Blue Shield. You will receive identification cards issued by Blue Cross and Blue Shield for hospital and physicians' services coverage.

The optional major medical benefits of the Program, which are paid for entirely by pensioners and surviving spouses electing such coverage, are provided in accordance with an agreement entered into by Colt Industries, Crucible Inc with Blue Cross and Blue Shield. You will not receive any identification card for optional major medical coverage, but if you elect such coverage the amount of premium deducted therefor will be reflected on your check stub.

The Pensioners' and Surviving Spouses' Health Insurance Agreement and the rules, regulations and arrangements referred to above form the basis on which the Program is administered, but if there is any inconsistency, such Insurance Agreement governs.

The name of the plan under which benefits are provided is the Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses. The employer identification number assigned by the Internal Revenue Service is 25-1194959 and the Plan Number is 527. This is a welfare benefit plan as defined by ERISA. The cost of administering the plan is paid by the Company. Records of the plan are kept on a calendar year basis.

Mrs. Joan Pastor, Director of Employee Benefits, Colt Industries, Crucible Inc, 430 Park Avenue, New York, New York 10022 is the plan administrator, and agent for service of legal process under the plan. The telephone number for the plan administrator is 212-940-0544.

As a participant in the plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the plan administrator's office or at the employee benefits office at the plant or office where you last worked, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your former employer, or union, or any other person, may discriminate against you in any way to prevent you from obtaining an insurance benefit or exercising your rights under ERISA.

If your claim for an insurance benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to appeal this denial in accordance with the provisions outlined in this summary plan description.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

IMPORTANT NOTICE

Since the Program includes those eligible for Medicare and does not replace the benefits provided by Medicare, it is essential that you and your dependents enroll for Medicare, including the voluntary Supplementary Medical Insurance provided under Part B of Medicare when eligible to do so (except as provided in paragraph 4.32). Otherwise, there will be a serious gap in your protection against hospital and medical expenses. (See paragraphs 4.28-4.32 for a more detailed explanation.)

Mr. ROYBAL. Thank you, Reverend.
The Chair now recognizes Mr. Gajda.

STATEMENT OF ANTHONY J. GAJDA

Mr. GAJDA. The issue of post retirement health care benefits is of recent vintage but it is nevertheless attracting increasing attention. To help define this issue, we have prepared summary, which you have in the written remarks, of three regional surveys conducted by our firm. The summary shows that 57 percent of firms provide health care benefits to their retirees; 89 percent of those firms that do provide coverage to the retirees also provide benefits to the retiree's spouse; 84 percent of firms that provide retiree medical benefits provide benefits that are equal to or better than the benefits available to that firm's active employees. Just under two-thirds of firms require retirees to pay some portion of the cost of their benefits and 31 percent of the firms require the retirees to pay 50 percent or more of their benefit costs.

Only two out of 294 firms that provide these benefits prefund the cost of retiree medical benefits.

The retiree benefit costs that are attracting attention today are the costs that are being paid today. Other speakers will be discussing the cost of retiree benefits and the effects of those costs on their current operations. In some instances, the cost of retiree benefits is growing faster than any other cost of doing business.

If, for example, retiree benefit costs increased at a rate of 12 percent per year and the number of retirees increases at the rate of 6 percent per year, then after 10 years total retiree benefit costs will have risen by 550 percent. If the benefit costs grow at 14 percent a year, then after 10 years total costs would have increased by 660 percent. These are not outlandish assumptions. These are very reasonable assumptions based on the kinds of inflation and cost growth we have seen in recent years.

In addition to health care cost inflation and the growth in the number of retirees, reductions in medicare benefits will directly shift costs to retiree medical plans.

Every increase in a part A deductible or a part B deductible or a change in the copayment levels or any other change that is designed to control medicare costs in turn will drive up the costs of retiree medical plans. Now, that is not to say that medicare should not be doing everything it can to control its own costs, but it does say that when medicare shifts the cost, many of these private sector retiree medical plans have to pick up that cost.

Consider the private firm that is facing a 500 percent or a 600 percent or an even greater increase in retiree medical plan costs during the coming decade. That firm will be concerned about a cost that is virtually out of control and may take steps to begin controlling its costs by reducing retiree benefits or by increasing retiree copayments or by increasing premium payments.

Now consider the retirees, who are already allocating a very large portion of their income to health care and who are now losing medical benefits or who are picking up larger copayments or having to pay larger premiums for their benefits. Those retirees may legitimately feel that they have been betrayed—that a prom-

ise of health care protection that was made to them years or even decades earlier has been broken.

The situation is very similar to the early days of pension, particularly in the public sector. In the late 19th or early 20th centuries, pensions were promised and given with no regard to the accruing liabilities. In New York City, for example, after a decade of escalating pension costs, a 1913 mayoral commission discovered that the city's annual pension cost was only the tip of the pension cost iceberg.

Today, firms are discovering that their current retiree medical costs are just the tip of the iceberg. Don Fuerst from our Los Angeles office will discuss the relationship between current retiree costs and ultimate retiree medical costs. But for the time being, it's sufficient to say that current retiree medical costs bear little resemblance to the actual or ultimate costs.

Returning to the issue of business concerns about rapidly rising retiree medical costs and to the preception by retirees that a promise has been broken, we can examine a dilemma faced by retirees.

If firms take the reasonable approach of increasing the retirees premiums in order to slow the firm's cost increases for retiree medical, then retirees have to make a judgment about whether they will receive medical benefits that will exceed their premium costs. In other words, if they buy the insurance, will they be better off? Will they collect more benefits? It's easy to see that the more healthy retirees will opt out and the less healthy retirees will remain in the plan. This process will lead to even greater increase in the total cost of the firm's retiree medical plan and, perhaps, another increase in retiree premium payments which starts the cycle all over again.

Fortunately, the number of firms that are facing these difficult problems is not now large. Most firms have not provided retiree benefits long enough or have very few retirees relative to active employees to be overwhelmed by retiree medical costs. But, unless sponsoring firms begin to make changes, retiree medical plan costs will become an increasingly widespread problem.

Our remarks today suggest that there are a number of problems that must be addressed with retiree medical plans. We believe that those problems can be addressed and we have attached a series of recommendations for change in retiree medical plans which will improve the understanding and management of these plans.

I will now turn over this presentation to Don Fuerst who will discuss probably the most important of our recommendations.

[The prepared statement of Mr. Gajda follows:]

PREPARED STATEMENT OF ANTHONY J. GAJDA, ECONOMIST, WILLIAM M. MERCER-MEIDINGER, INC., NEW YORK, NY

The issue of post-retirement health care benefits is of relatively recent vintage but is, nevertheless, attracting increasing attention.

Post-retirement health care benefits are medical, surgical, hospital and other health benefits that are provided to the retirees of a firm by virtue of those employees having rendered some stipulated length of service with the firm prior to retirement.

To help define the issue, we have prepared a summary of three regional surveys conducted by our firm.

The summary shows that: 57 percent of firms provide health care benefits to their retirees; 89 percent of firms which provide health care benefits to retirees provide

coverage also to their spouses; 84 percent of firms provide retiree medical benefits that are equal to or better than the benefits of active employees. 64 percent of firms require retirees to pay some portion of the cost of benefits and 31 percent of firms require retirees to pay 50 percent or more of the costs; and, only 2 out of 294 firms prefund the cost of retiree medical benefits.

In this setting, we would like to disuss three problems associated with postretirement health care benefits.

Those problems are: emerging costs, the effects of cost-shifting, and, the dilemma of retirees.

The retiree benefit costs that are attracting attention today are the costs that are being paid today.

Other speakers will be talking about the costs of retiree benefits and the effect of those costs on their current operations. In some instance, the cost of retiree benefits is growing faster than any other cost of doing business.

If, for example, retiree benefit costs increase at the rate of 12 percent per year and the number of retirees grows at the rate of 6 percent per year, then after 10 years, total retiree benefit costs will have increased by 550 percent. If benefit costs grow at 14 percent, then the 10-year cost growth will be 660 percent. These assumptions are reasonable based on recent experience.

In addition to health care cost inflation and growth in the number of retiree, reductions in medicare benefits will directly shift costs to most retiree medical plans. Every increase in the part "A" or part "B" deductibles, or the shift to the 75th percentile for physician reimbursement, or increases in co-payments, or any other change designed to control the cost of medicare, in turn, will drive up the cost of retiree medical plans. That is not to say that medicare should not attempt to control its own costs, but it is to say that those cost shifts are exacerbating the retiree medical plan cost problems.

Consider the private firm that that is facing a 500 percent, or 600 percent or an even larger increase in retiree medical plan costs during the coming decade. That firm will be concerned about a cost that is virtually out of control and may take steps to begin controlling its costs by reducing retiree benefits or by increasing retiree copayments or by increasing retiree premium payments.

Now consider the retirees, who already are allocating a large portion of their income to health care, and who are now losing medical benefits or who are picking up larger co-payments or who are paying larger premiums for their benefits. Those retirees may legitimately feel that they have been betrayed—that a promise of health care protection made years or decades earlier has been broken.

This situation is very similar to the early days of pensions, particularly in the public sector. In the late-19th and early-20th centuries, pensions were promised and given with no regard to accruing liabilities. In New York City, for example, after a decade of escalating pension costs, a 1913 Mayoral Pension Commission discovered that the city's annual pension cost was only the tip of the pension cost iceberg.

Today, firms are discovering that their current retiree medical plan costs are just the tip of the iceberg.

Don Fuerst, from our Los Angeles office, will discuss the relationship between current retiree medical costs and ultimate retiree medical costs. For the time being, it is sufficient to say that current retiree medical costs bear little resemblance to actual or ultimate retiree medical costs.

Returning to the issue of business concerns about rapidly rising retiree medical costs and to the perception by retirees that a promise has been broken, we can examine a dilemma faced by retirees.

We reported earlier that our surveys showed that 64% of retirees pay some portion of the cost of their medical benefits and that 31 percent pay 50 percent or more of the cost.

If firms take the reasonable approach of increasing retiree premium payments in order to slow the firm's increase in retiree medical plan costs, then retirees have to make a judgement about whether they will receive medical benefits that will exceed their premium costs. It is easy to see that the more healthy retirees will opt out and the less healthy retirees will remain in the plan. This process will then lead to even greater increase in the total cost of the firm's retiree medical plan and, perhaps, another increase in retiree premium payments which starts the cycle all over again.

Fortunately, the number of firms that are facing these difficult problems is not large. Most firms have not provided retiree benefits long enough or have very few retirees relative to active employees to be overwhelmed by retiree medical costs. But, unless sponsoring firms begin to make changes, retiree medical plan costs will become an increasingly widespread problem.

Our remarks today suggest that there are a number of problems that must be addressed with retiree medical plans. We believe that those problems can be addressed and we have attached a series of recommendations for change in retiree medical plans which will improve the understanding and management of these plans.

I will now turn over this presentation to Don Fuerst who will discuss the most far-reaching of our recommendations.

Recommendations for Retiree Medical Plans

1. Retiree medical plan cost data should be maintained and reported separately from the cost data of active employee plans

Many firms do not maintain separate cost and utilization data for their retiree plans. As a consequence, they cannot know the implications of external events such as a change in medicare benefits or a change in the age of medicare eligibility. Nor can firms know if they suffer excessive utilization or the effect of a change in their early retirement age or the savings that they can expect from cost control initiatives.

Accumulating cost and utilization data for retiree medical plans is a logical and necessary first step.

2. Retiree medical plans should be designed to provide benefits efficiently

As Mercer-Meidinger surveys have shown, many firms provide retiree plans which are coordinated with medicare so that retirees will almost always receive full reimbursement of their expenses and more than active employees receive. A plan designed to coordinate with medicare provides no incentive for retirees to obtain health care efficiently and economically.

Retiree medical plans should include some cost-sharing features to restrain utilization.

3. Retiree medical plans should include cost containment features

While active employee medical plans are being changed with increasing frequency to include such cost containment features as hospital pre-certification, second surgical opinions, ambulatory surgery, alternate care facilities, etc., those changes are not being made in retiree medical plans with the same frequency.

With minor exceptions, the whole range of cost containment techniques that are being installed in active employee plans should be installed in retiree plans.

4. Retiree medical plan costs should be prefunded

The dominant practice among firms is to charge the cost of retiree medical plans as employees retire and begin to claim benefits—a pay-as-you-go or unfunded basis. Even though employees earn the right to benefits every year, just as with pensions, firms do not put aside monies for the accruing liability. As employees retire and begin to claim medical benefits the cost of these plans begins to grow at a disproportionate rate.

Firms should prefund the cost of retiree medical benefits so that ample funds are available as employees retire and begin to claim benefits; so that the cost of those benefits can be converted to a relatively constant annual cost; and, so that the true cost of employment will be known.

5. A national health care policy should be developed to restrain cost growth

Health care costs and cost inflation are a difficult problem for everyone and are more of a problem for the aged because of their generally lower income levels. In many instances active and retired employee medical plan costs are the most intractable problems faced by business. Unfortunately, some plans solve the problem by reducing or eliminating benefits thereby negating the economic and social gains that are associated with a healthy population. As the health care inflation problem intensifies so will reactions.

As a nation, America has affirmed and re-affirmed its belief that access to health care and a healthy population are in the national interest. The federal government should take the lead in assuring that health care is accessible at a reasonable cost.

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SUMMARY OF SURVEYS REGARDING POST-RETIREMENT MEDICAL BENEFIT PLANS

	Survey No. 1		Survey No. 2		Survey No. 3		Combined	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
A. Retiree coverage:								
Respondents providing retiree medical benefits	31	72	137	55	126	56	294	57
Respondents not providing retiree medical benefits	12	28	111	45	99	44	222	43
Total respondents	43	100	248	100	225	100	516	100
B. Spouse coverage:								
Respondent providing spouse coverage	13	42	124	91	124	98	261	89
Respondents not providing spouse coverage	18	58	13	9	2	2	33	11
Total respondents	31	100	137	100	126	100	294	100
C. Benefit level-non-medical eligible:								
Same as active employees	26	84	111	81	111	88	248	84
Less than active employees	5	16	18	13	10	8	33	11
No response	0	0	8	6	5	4	13	5
Total	31	100	137	100	126	100	294	100
D. Benefit level-medicare eligible:								
Medicare coordination (plan pays difference between medicare payments and actual expenses but no more than 100 percent of expenses)	12	39	52	38	49	39	113	38
Medicare supplement (plan pays the same as for an active employee less medicare payments)	19	61	68	50	45	36	132	45
Fixed schedule of allowances	0	0	3	2	3	2	6	2
Other or no response	0	0	14	10	29	23	43	15
Total	31	100	137	100	126	100	294	100
E. Retiree share of costs:								
Retiree (in percent):								
None	17	56	59	42	31	25	107	36
1 to 50	7	22	27	20	22	17	56	19
51 to 99	0	0	10	7	4	3	14	5
100	7	22	27	20	41	33	75	26
No response	0	0	14	1	28	22	42	14
Total	31	100	137	100	126	100	294	100
Spouse coverage (in percent):								
None	9	29	48	35	23	18	80	27
1 to 50	6	19	30	22	20	16	56	19
51 to 99	4	13	13	9	7	6	24	8
100	12	39	33	24	42	33	87	30
No response	0	0	13	10	34	27	47	16
Total	31	100	137	[illegible]	126	100	294	100
F. Financing:								
Pre-Funded	0	0	0	0	2	2	2	1
Pay-as-you-go	31	100	137	100	124	98	292	99
Total	31	100	137	100	126	100	294	100

Notes to survey summary:
Survey No. 1 was conducted in the Chicago area in the spring of 1983 by mailing a questionnaire to the 200 largest firms in the metropolitan area.
Survey No. 2 was conducted in the California area by mailing a questionnaire to 1,077 firms.
Survey No. 3 was conducted in the Minnesota area by mailing a questionnaire to 410 metropolitan area firms.

Mr. ROYBAL. The Chair now recognizes Mr. Fuerst.

STATEMENT OF DONALD E. FUERST

Mr. FUERST. Thank you, Mr. Chairman. Ny name is Don Fuerst. I am an actuary and I am here to give you some of my opinions concerning this issue. I should mention that these are my own opinions, not necessarily those of my employer or my client.

The postemployment medical plan is often viewed as a promise to the employee of the payment of benefits in kind in exchange for the services rendered during the employee's working career. The employee fulfills his end of this implicit contract by working and providing services currently. The employer must provide his portion of the contract at a later date. This later fulfillment of the promise by the employer causes potential problems.

Benefits may cost considerably more at a later date due to inflation in the cost of medical services or potential cutbacks in the current level of medicare benefits.

Second, retirees may be a substantially larger burden relative to the active work force at a future date. This is particularly true in industries that are maturing or declining in work force.

Third, the employer may not be immortal. The employer may not be able to fulfill the promise because of economic conditions despite the desire to provide the benefits.

Many employers are not aware that the small current costs may escalate. Many companies have analyzed the commitment or the promise which they have made strictly on a pay-as-you-go data with insufficient future projections of the costs.

Other companies have taken the time to examine future cash outlays and methods of funding or expensing. Most have chosen to postpone the recognition of these expenses, perhaps because of the competitive pressures to keep expenses down in order to price their services competitively.

A very small portion of companies have chosen to recognize the future benefit payments during the working career of the employees and have attempted to fund for these plans through such mechanisms as a voluntary employee benefit association, a 501(c)(9) trust. These employers have been very concerned in recent months as legislation has been considered which would restrict the ability to utilize this trust as a funding mechanism.

We have assisted one of our major clients in determing the future benefits involved in this promise that they have made to their employees. We have presented some summary information from this case study for the record and for your consideration. This material represents the analysis of a major employer with over 50,000 employees and a two-part benefit plan which provides a continuation of the active employee medical plan to early retirees until age 65 and a medicare supplement plan after age 65.

The case study illustrates that medical benefit payments will sharply accelerate in the future if medical inflation continues and as the number of retirees substantially increases in future years. The exhibits in our report also show that if the medical plan were to be funded on a basis similar to this company's pension plan, the current expense would be approximately 3.7 times greater than the current pay-as-you-go costs which the company has been recognizing.

This much higher expense level would be approximately 2.6 percent of the total payroll of the company. While this is a large expense, it's not as large as the pension expense which is 11.3 percent of payroll. The medical benefits in comparison to pension benefits, are relatively small. Yet the unfunded nature of this benefit produces a substantial leveraging impact.

For instance, in this plan the accrued liability of the medical plan is only 17 percent of the accrued liability of the pension plan computed on the same basis and assumptions. Yet, because the pension plan has been funded for many years and developed a funding ratio of over 55 percent, the pension plan has considerable assets to support the liabilities which have accrued. The medical plan has no assets to support the promise.

As a result, the unfunded liability of the medical plan represents 38 percent of the pension plan's unfunded liability. Medical benefits are different from pension benefits in many respects and funding these plans at the levels required for pension plans is probably not necessary. Yet both do provide a deferred benefit to employees many years after the benefit was earned.

The only assurance that many employees have that this commitment will be fulfilled is the continued willingness and ability of the employer to meet the obligation. Funded retiree medical plans would enhance the security of current and future retirees. However, funding on a level comparable to pension plans would be sudden and drastic change which might produce the undesirable effect of many plan terminations. Gradual implementation of reasonable funding requirements with ample transition periods should be encouraged.

Thank you.

[The prepared statement of Mr. Fuerst follows:]

PREPARED STATEMENT OF DONALD E. FUERST, F.S.A.

THE COST OF POSTEMPLOYMENT MEDICAL BENEFITS

The postemployment Medical plan is often viewed as a promise to the employees of the payment of benefits in kind in exchange for the services renedered during the employees's working career. The employee fulfills his end of this implicit contract by working and providing services currently. The employer must fulfill his portion of the contract at the later date. This later fulfillment of the promise by the employer causes potential problems:

1. Benefits may cost considerably more at a later date due to inflation in the cost of medical services, or potential cutbacks in the current level of Medicare benefits.
2. Retirees may be a substantially larger burden relative to the active work force at a future date. This is particularly true in industries that are maturing or declining in workforce.
3. The employer may not be "immortal". The employer might be unable to fulfill the promise because of economic conditions, despite the desire to provide the benefits.

Many employers are not aware that the small current cost may escalate. Many companies have analyzed the commitment or the promise which they have made strictly on a pay-as-you-go basis with insufficient future projects of the cost.

Other companies have taken time to examine future cash outlays and methods of funding or expensing. Most have chosen to postpone recognition of these expenses, perhaps because of the competitive pressures to keep expenses down in order to price their products or services competitively.

A very small portion of companies have chosen to recognize the future benefit payments during the working career of the employees and have attempted to fund for these plans through such mechanisms as a voluntary employee benefit association, a 501(c)(9) trust. These employers have been concerned in recent months as leg-

islation has been considered which would restrict the ability to utilize this trust as a funding mechanism.

We have assisted one of our major clients in determining the future benefits involved in the promise they have made to their employees. We have presented some summary information from this case study for your consideration today. This material represents the analysis of a major employer with over 50,000 employees and a two-part benefit plan which provides a continuation of the active employees Medical plan to early retirees until age 65 and a Medical Suppplement plan for retirees after age 65.

The case study illustrates that the medical benefit payments will sharply accelerate in the future if medical inflation continues and as the number of retirees substantially increases in future years. The exhibits also show that if the medical plan were to be funded on a basis similar to this company's pension plan, the current expense would be approximately 3.7 times greater than the pay-as-you-go cost, which the company has been recognizing in the past. This much higher expense level would represent approximatly 2.6 percent of the total payroll of this company. While this is a large expense, it is less than the current pension expense of 11.3 percent of payroll.

The medical benefits, in comparison to pension benefits, are relatively small, yet the unfunded nature of these benefits produces a substantial leveraging impact. For instance, in this plan the accrued liability of the medical plan is only 17 percent of the accrued liability of the pension plan (computed on the same actuarial assumptions and funding method). Yet, becuase the pension plan has been funded for many years and has developed a funding ratio of over 55 percent, the pension plan has considerable assets to support the liabilities which have accrued. The medical plan has no assets to support the accrued liabilities. As a result, the unfunded liability of the medical plan represents 38 percent of the unfunded liability of the pension plan.

Medical benefits are different from pension benefits in many respects, and funding these plans at the levels required of pension plans is probably not necessary. Yet both provide a deferred benefit to an employee many years after the benefit was "earned." The only assurance that many employees have that this commitment will be fulfilled is the continued willingness and ability of the employer to meet the obligation.

Funded retiree medical benefit plans would enhance the security of current and future retirees. However, funding on a level comparable to pension plans would be a sudden and drastic change which might produce the undesirable effect of many plan terminations. Gradual implementation of reasonable funding requirements with ample transition periods should be encouraged.

CASE STUDY—PENSION VERSUS MEDICAL FUNDING

	Pension	Medical	Medical as percent of pension
1 Accrued liability	$2,472	421	17
2 Assets	1,358	0	0
3 Unfunded liability	1,114	421	38
4 Funding ratio = (2) ÷ (1) (percent)	55	0 0	

CASE STUDY

Actuarial assumptions

The expected medical benefit payment to early retirees for 1983 was projected using a regression analysis based on 1982 actual claim experience. The expected medical benefit payment for retirees over age 65 was also based on 1982 actual claim experience, but was substantially modified by manual rates because the current population over age 65 is not entirely eligible for the plan. Only retirees since 1978 are eligible for the Medicare Supplement Plan.

Expected average payments for 1983 are $1,600 for retired employees under age 65, and $370 for retired employees age 65 and over.

The present value of future benefit payments has been calnculated using an interest rate of 8 percent.

The annual increase in medical benefits due to inflation and increased utilization is assumed to be 10 percent. Actual increases in recent years have been greater. Increase rates of 6, 8 and 12 percent are also illustrated.

The mortality, turnover and salary increase assumptions are the same as those used in the actuarial valuation of the pension plans for this employer. The retirement assumption used in the pension valuation (everyone retiring at age 62) has been modified to a probability of retirement at each age from 55 to 65. This probability table is essential in determining the value of the early retirement medical benefits. The probabilities selected were based on recent retirement patterns.

Retirees under age 65 are required to contribute part of the plan cost. Currently retirees contribute $10 per month for single coverage and $20 per month for retiree and dependent coverage. We have assumed that the retiree contribution rate will increase in future years at the same rate as medical inflation. In other words, retirees will continue to fund the same proportion of expense that they currently fund.

UNIT CREDIT METHOD—THE BENEFIT APPROACH

The United Credit method attributes a portion of benefit to each year. The cost for that year is merely the present value of the benefit attributed. The method has sound reasoning when applied to pension plans in which an individual's benefit entitlement actually increases with each additional year of service.

Medical benefits, however, are generally on an all or none basis. The amount of benefit is the same for a 10-year or 30-year employee, and the benefit is paid only if the employee retires from active service. The benefit does not become "vested" until retirement age.

Nevertheless, the Unit Credit method may be applied to these benefits. We have allocated equal amounts of benefit to each year of an employee's service. A 30-year employee earns $\frac{1}{30}$ of the total benefit each year. The benefit for a 10-year employee is $\frac{1}{10}$ of the total benefit each year. If the 30-year and 10-year employees are the same age with the same expected retirement age, the benefit for the 10-year employee will be three times higher. The benefit allocated to each year for an individual employee is constant, but as his age increases the present value and the related expense increases each year.

The Unit Credit method produces an accrued liability. The accrued liability is the present value of benefits attributed to all past years. For example, a 50 year old employee who was hired at age 35 and was expected to retire at age 65, would have "accrued" 50 percent of his ultimate benefit. The present value of 50 percent of his benefit would have accrued in previous years and is therefore considered an accrued liability. Because this amount has not yet been expensed, it is generally amortized over a fixed number of years, say 20 or 30 years.

ENTRY AGE METHOD—LEVEL COST ALL YEARS

The Entry Age Method differs from the Unit Credit because it does not allocate benefits. The Entry Age Method calculates the amount needed at retirement to fund the benefit, and determines a level cost for each year of employment. Often the cost is determined as a level percentage of compensation. The cost for a particular employee depends only upon his age at hire and his compensation, if the level percent of compensation method is used. This report utilizies the level percent method. The level dollar method would produce higher accrued liabilities and a higher cost than the level percent method.

The Entry Age Method differs from the United Credit because it does not allocate benefits. The Entry Age Method calculates the amount needed at retirement to fund the benefit, and determines a level cost for each year of employment. Often the cost is determined as a level percentage of compensation. The cost for a particular employee depends only upon his age at hire and his compensation, if the level percent of compensation method is used. This report utilizes the level percent method. The level dollar method would produce higher accrued liabilities and a higher cost than the level percent method.

The Entry Age Method generally produces higher cost than the Unit Credit Method in an employee's early years, and lower cost in later years. Overall, the cost is the same, because the benefit is the same.

The Entry Age Method produces an accrued liability equal to the level cost which would have been expensed or funded in past years if the method had always been used.

AGGREGATE METHOD

The third method considered, the Aggregate Method, is similar to the Entry Age Method. Both methods determine the amount needed at retirement to fund the benefit. The Aggregate Method then determines the level cost from the current date to retirement. No cost is allocated to previous years, therefore, there is no accrued liability and no amortization charge, but the normal cost allocated to each future year is substantially higher.

SUMMARY

Each of these methods accumulate by retirement date the necessary reserve to fund an employee's benefits if the method is applied in all years, and if actuarial assumptions are realized. The ultimate cost of each method (when adjusted for the time value of money) is the same. Only the incidence of cost changes. Yet this change in the incidence of cost can be substantial. The following table summarizes the accrued liability and total cost in 1983 for these three methods (using a 30-year amortization).

[Dollars in millions]

	Unit credit	Entry age	Aggregate
Present value of all projected	$611.7	$611.7	$611.7
Accrued liability	336.7	421.1	0
Total annual cost (1983)	44.5	53.9	61.8
Annual cost as percent of active payroll	2.17	2.63	3.01

The cost under the Unit Credit Method will increase as the participants age and as medical inflation continues. The cost of the Entry Age and Aggregate Methods will increase as total payroll increase, since future normal costs have been allocated in proportion to anticipated compensation.

ACTUARIAL ASSUMPTIONS

1. Interest: Eight percent compounded annually.
2. Mortality: 1951 male group annuity table, projected to 1960, set back 1 year for males and 6 years for females.
3. Termination: Sample rates of termination are shown below:

[In percent]

Age:	Rate
20	25.0
30	12.0
40	5.0
50	2.5
60	0.5

4. Salary scale: Sample annual increases are as follows:

[In percent]

Age:	Rate
20	8.5
30	8.5
40	7.7
50	6.4
60	5.4

5. Retirement: Active lives are assumed to retire in accordance with the following table:

[In percent]

Age:	Rate
Less than 55	0
55	3
56	3
57	3

58	4
59	4
60	5
61	5
62	20
63	25
64 and over	100

6. Average annual medical benefit payment: For retirees under age 65, $1,600. For retirees at least age 65, $370.

7. Medical cost inflation: The assumed annual rate of increase in the cost of medical benefits was determined using rates of 6, 8, 10, and 12 percent.

8. Pre-age 65 annual increse in monthly contribution rates: The same as shown in (7) above.

9. Percent of pre-age 65 retirees making required contributions to participate in the medical plan: 93 percent.

10. Percent of pre-age 65 retirees who have sponses and/or dependents: 70 percent.

SUMMARY OF PLAN BENEFITS

Comprehensive plan—early retirement plan

Eligibility: Retirees age 55 through 64 and disability retirees (under age 65) who receive monthly early retirement or disability retirement benefits. Dependents are also eligible. Retirees over age 65 may cover their dependents (other than spouse) under early retiree plan. Coverage will be continued after the death of the retiree for the spouse of retiree. The company pays full cost of continued coverage. Retiree must have been covered as an active employee on the day before he becomes a retired employee.

Retired employee contribution: $10.00 per month—retiree only or dependents only, $20.00 per month—Retiree and dependents.

Deductible: $50 per calendar year per person.

Benefits: Plan pays 80 percent of eligible medical expenses (50 percent for mental and nervous conditions) up to $5,000; 100 percent thereafter to $250,000.

Lifetime maximum: $250,000 per person.

Medicare supplement plan—Retirees over age 65 plan

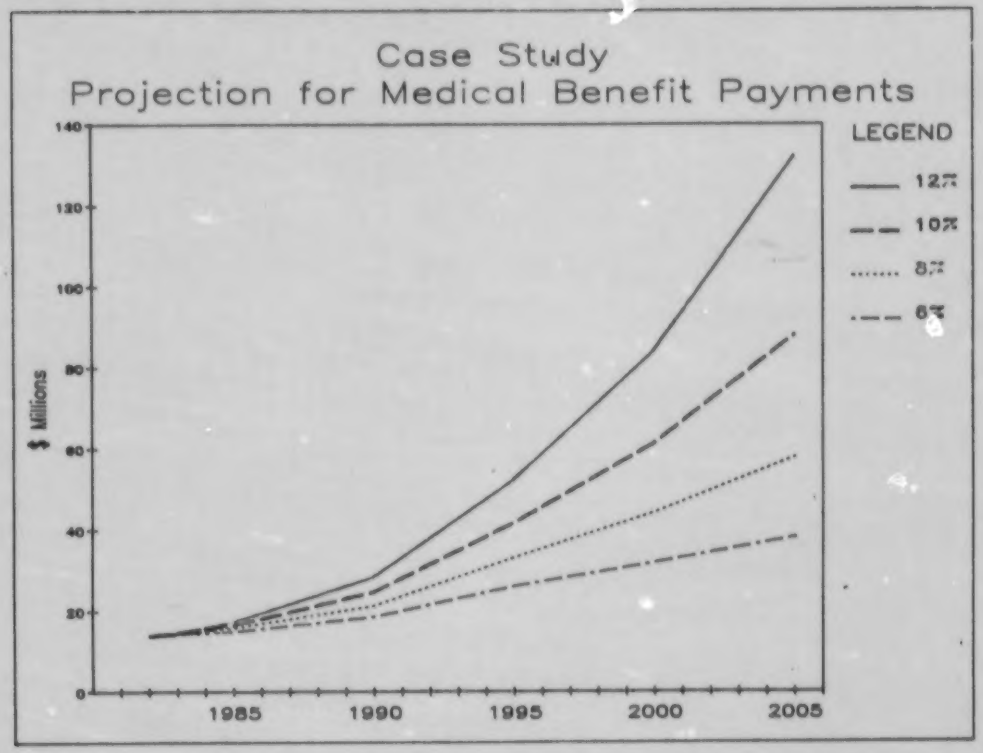
Eligibility: Retirees age 65 and over who begin to receive monthly retirement benefits after January 1, 1978. Spouses over age 65 are covered. Spouses coverage ceases upon death of retiree. Retiree must also have been covered as an active employee on the day before he becomes a retired employee.

Retired employee contribution: None.

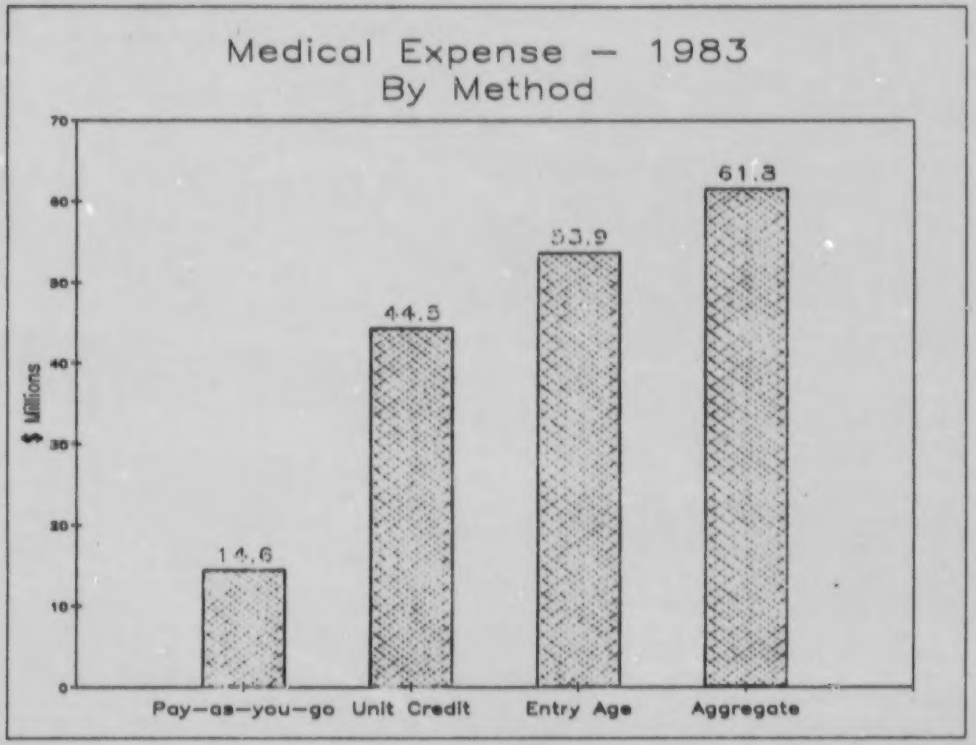
Deductible: $100 per calendar year per person and benefits provided under medicare or any other employer or government program.

Benefits: Plan pays 80 percent of eligible medical expenses (50 percent for Mental and Nervous conditions) up to $5,000.

Lifetime maximum: $5,000 per person; however, up to $1,000 of the maximum is reinstated each year as necessary to restore the $5,000 maximum.


Case Study
Projection for Medical Benefit Payments
$ Millions
140
120
100
80
60
40
20
0
1985
1990
1995
2000
2005
LEGEND
12%
10%
8%
6%

53


Medical Expense – 1983
By Method
$ Millions
70
60
50
40
30
20
10
0
14.6
44.5
53.9
61.8
Pay–as–you–go
Unit Credit
Entry Age
Aggregate

Mr. ROYBAL. Thank you, Mr. Fuerst.
The Chair now recognizes Mr. Lynch.

STATEMENT OF LEON LYNCH

Mr. LYNCH. Thank you, Mr. Chairman. My name is Leon Lynch and I am the international vice president for United Steelworkers of America.

The topic of today's hearing: "Corporate Retiree Health Benefits: Here Today, Gone Tomorrow?" is a particularly timely one for our union. The retiree health benefits which we have negotiated for thousands of our members are the focus of critical attention by employers in all of the major industries in which we represent employees. In some cases employers have actually terminated retiree health care benefits; in others, employers are threatening to do so.

Where employers have not disavowed their obligations to retirees, active employees are increasingly being required to accept wage and benefit concessions in order to protect the entitlements of their brothers and sisters who retired in years past.

These problems stem in large part from the phenomenal increases in health care costs which have taken place in recent years. The impact of these costs on the collective bargaining process is dramatic. Employers more and more frequently attempt to penalize our members at the bargaining table because of these increasing costs. Employers demand reductions in coverage, increases in deductible and copayments and other devices which serve only to shift health care costs from the employer to employees.

To date, the union has been largely successful in resisting these artificial attempts at so-called health care cost containment. We have joined with responsible employers in urging our members to participate in health maintenance organizations, preferred provider organizations, wellness programs and other legitimate efforts to contain health care costs in ways which do not jeopardize the ability of our members to receive quality health care.

With regard to retiree health care benefits, the impact of the growth in the cost of medical care has been even more dramatic. Obviously, the cost of these retiree benefits has increased along with the cost of health care benefits for active employees. However, because these retiree insurance programs typically carve out benefits provided under medicare from the benefits for which the employer is responsible, the reductions in medicare coverage in recent years have significantly increased the cost to employers of providing retiree health care benefits.

For example, the medicare hospital deductible—equivalent to the average cost of 1 day in the hospital—has risen from $52 in 1970 to $356 in 1984 and is expected to increase to $800 in 1995. The daily co-payment for long-term hospital stays has risen from $10 to $89 between 1965 and 1984. As the portion of basic health care costs provided by medicare decreases, the portion which becomes the responsibility of the employer increases. The price tag is substantial. So-called medicare cost containment is in many cases merely a shifting of costs from the Federal Government to private-sector retiree insurance programs. We negotiated carve-out programs to protect our retired members against the impact of reductions in

medicare benefits and we take comfort in knowing that our retired members are in many instances protected against the impact of the continuing medicare cutbacks which Congress is imposing under current budget constraints.

However, we are also keenly aware the employers will not absorb these increased costs forever. Whether due to the effects of the Reagan recession, fundamental management errors or cold-hearted business decisions to reduce expenses, we have been confronted in recent years with numerous instances in which employers have defaulted on their promise to provide lifetime health care benefits for retirees and their dependents.

The public media has highlighted one example, that of Colt Industries. That company committed itself to provide its retirees health care. When it closed its plant in Midland, PA, it told the hundreds of employees who applied for retirement that they had no need to worry about insurance coverage—insurance was theirs for life. Later, corporate officials balked at the expense of redeeming this pledge. Colt threatened to cancel the retiree insurance benefit. The issue now rests with the courts.

Once in court, at least at the appellate levels, the retirees fare well. Their efforts, though, are lengthy and largely their own. Although ERISA clearly authorizes the Secretary of Labor's intervention on behalf of these retired participants, the Reagan administration has turned away. I am unaware of even a single instance where this administration has brought its powerful office to bear on retirees' behalf in an insurance lawsuit. Our own requests for assistance go unanswered.

As a result of the administration's refusal to act, retirees are left only to themselves and the assistance which the unions which won these benefits can offer. In courts, they face the formidable job of fashioning ERISA's common law to reflect a simple, commonsense principle: The grant of a benefit to a retiree inherently carries the presumption of benefit for life.

Some courts, awed by the tremendous costs involved, are reluctant to offer explicit endorsement to this principle of basic fairness.

Much in ERISA supports the retirees' claims. The statute's reporting the disclosure requirements argue forcefully against a company's exercising a right to terminate which it has not clearly communicated. The law best serves ERISA's bedrock goal of protecting participant interests by incorporating in the statute's common law a presumption of benefit continuity where the documents controlling the plans don't clearly express limits.

As I have already noted, retirees are handicapped in making these arguments by the Secretary's failure to join the fight. Absent the administration's forceful intervention to describe ERISA's comprehensive policies, many courts view the litigation following benefit termination as no more than a commercial lawsuit between private litigants.

The time may have arrived for Congress to consider legislative initiatives to clarify ERISA's subsisting purposes. For instance, Congress could remind the courts of ERISA's teeth and forbid employers from asserting termination rights that aren't disclosed in compliance with the statute's requirements. Similarly, Congress could remind Federal courts that their mandate to fashion a

common law of employee benefits is a serious one which should embrace the progressive doctrines State courts were developing on the eve of ERISA's enactment.

So long as health care costs in our society continue to increase at a far greater rate than other segments of the economy, the pressure by employers to limit their expenses by reducing retiree health care benefits—regardless of the legalities—will continue. Congress must enact meaningful health care cost containment legislation if retirees are to receive the benefits promised them by their employers.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Lynch follows:]

PREPARED STATEMENT OF LEON LYNCH, VICE PRESIDENT (HUMAN AFFAIRS), UNITED STEELWORKERS OF AMERICA, PITTSBURGH, PA

The United Steelworkers of America, on behalf of our more than 1 million active and retired members, is pleased to have the opportunity this afternoon to testify before the House Aging Committee. Our Union has long believed that it is a fundamental obligation of employers to provide comprehensive health insurance to their employees and retirees. We are proud that we have been able to win at the bargaining table quality health care coverage for almost all of the employees we represent and for many thousands of our retired members as well. We are also proud of our record, both here in Congress and in state legislatures, of support for government sponsored health care for our elderly and those who are in need. It has long been a tenet of our Union that all members of our society are entitled to quality health care, and it is in furtherence of that goal that we testify here today.

The topic of today's hearing—Corporate Retiree Health Benefits—Here Today, Gone Tomorrow—is a particularly timely one for our Union. The retiree health benefits which we have negotiated for thousands of our members are the focus of critical attention by employers in all of the major industries in which we represent employees. In some cases employers have actually terminated retiree health care benefits; in others, employers are threatening to do so. Where employers have not disavowed their obligations to retirees, active employees are increasingly being required to accept wage and benefit concessions in order to protect the entitlements of their brothers and sisters who retired in years past.

These problems stem in large part from the phenomenal increases in health care costs which have taken place in recent years. We are all familiar with the statistics. Health care spending as a percentage of the nation's gross national product has grown from only 6.5% in 1965 to 10.5% in 1982. In terms of dollars, national health expenditures rose from $41.7 billion in 1965 to $322.4 billion in 1982.[1] It has been estimated that this figure will grow to well over $800 billion by 1990.[2]

Particularly significant is the rate of growth in national health care costs. It is estimated that the per capita cost from 1960 to 1990 will have increased by over 2000 percent or four times faster than the Consumer Price Index for the same period.[3] In 1983 alone, hospital costs increased three times as fast as the CPI.[4]

The impact of these costs on the collective bargaining process is dramatic. Employers more and more frequently attempt to penalize our members at the bargaining table because of these increasing costs. Employers demand reductions in coverage, increases in deductible and co-payments and other devices which serve only to shift health care costs from the employer to employees.

To date, the union has been largely successful in resisting these artificial attempts at so-called health-care cost containment. We have joined with responsible employers in urging our members to participate in health maintenance organizations, preferred provider organizations, wellness programs, and other legitimate efforts to contain health-care costs in ways which do not jeopardize the ability of our members to receive quality health care.

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[1] The New Times, January 22, 1984.
[2] "Managing Health Cost: Strategies for Coalitions and Business," U.S. Chamber of Commerce, p. 37.
[3] "Background Material" on H.R. 4870 prepared by legislative staff.
[4] Id.

With regard to retiree health care benefits, the impact of the growth in the cost of medical care has been even more dramatic. Obviously, the cost of these retiree benefits has increased along with the cost of health care benefits for active employees. However, because these retiree insurance programs typically "carve out" benefits provided under Medicare from the benefits for which the employer is responsible, the reductions in Medicare coverage in recent years have significantly increased the cost to employers of providing retiree health care benefits. For example, the Medicare hospital deductible—equivalent to the average cost of one day in the hospital—has risen from $52 in 1970 to $356 in 1984 and is expected to increase to $800 in 1995.[5] The daily copayment for long-term hospital stays has risen from $10 to $89 between 1965 and 1984.[6] As the portion of basic health care costs provided by Medicare decreases, the portion which becomes the responsibility of the employer increases. The price tag is substantial. It is reported that the latest increase in the Medicare hospital deductible alone costs a corporation such as Chrysler in excess of $1 million annually.[7] The impact is no less at companies with which our Union negotiates. So-called Medicare cost containment is in many cases merely a shifting of costs from the federal government to private-sector retiree insurance programs. We negotiated "carve-out" programs to protect our retired members against the impact of reductions in Medicare benefits and we take comfort in knowing that our retired members are in many instances protected against the impact of the continuing Medicare cutbacks which Congress is imposing under current budget constraints.

However, we are also keenly aware that employers will not absorb these increased costs forever. Whether due to the effects of the Reagan recession, fundamental management errors or cold-hearted business decisions to reduce expenses, we have been confronted in recent years with numerous instances in which employers have defaulted on their promise to provide lifetime health care benefits for retirees and their dependents.

The public media has highlighted one example, that of Colt Industries. That company committed itself to provide its retirees health care. When it closed its plant in Midland, Pennsylvania, it told the hundreds of employees who applied for retirement that they had no need to worry about insurance coverage—incurance was theirs for life. Later, corporate officials balked at the expense of redeeming this pledge. Colt threatened to cancel the retiree insurance benefit. The issue now rests with the courts.

Colt is a significant example, but hardly the only one. At the bunker Hill mines in Idaho, the Connors Steel Company in West Virginia, the Teledyne-Mt. Vernon plant in Connecticut, in the Bessemer Cement mill in Pennsylvania—at plants all over the country—employers are cutting off benefits and putting their retirees to the anxious, expensive and lengthy task of proving their entitlement in court.

Once in court, at least at the appellate levels, the retirees fare well. Their efforts, though, are largely their own. Although ERISA clearly authorizes the Secretary of Labor's intervention on behalf of these retired participants, the Reagan administration has turned away. I am unaware of even a single instance where this administration has brought its powerful office to bear on retirees' behalves in an insurance lawsuit. Our own requests for assistance go unanswered.

As a result of the administration's refusal to act, retirees are left only to themselves and the assistance which the unions which won these benefits can offer. In courts, they face the formidable job of fashioning ERISA's common law to reflect a simple, common sense principle: the grant of a benefit to a retiree inherently carries the presumption of benefit for life. Some courts, awed by the tremendous costs involved, are reluctant to offer explicit endorsement to this principle of basic fairness. Ironically, though, corporate officials grasp it. In time and again assuring their retirees that their benefit lasted for life, companies recognize that a benefit earned by years of service is one which lasts throughout retirement. Indeed, companies often book the prospective costs of these benefits and deduct them from income for tax purposes.

Much in ERISA supports the retirees' claims. The state's reporting and disclosure requirements argue forcefully against a Company's exercising a right to terminate which it has not clearly communicated. The law best serves ERISA's bedrock goal of protecting participant interests by incorporating in the statute's common law a presumption of benefit continuity where the documents controlling the plans don't clearly express limits. As I have already noted, retirees are handicapped in making these arguments by the Secretary's failure to join the fight. Absent the administra-

[5] Id.
[6] The New York Times, May 6, 1984.
[7] Id.

tion's forceful intervention to describe ERISA's comprehensive policies, many courts view the litigation following benefit termination as no more than a commercial lawsuit between private litigants.

The time may have arrived for Congress to consider legislative initiatives to clarify ERISA's subsisting purposes. For instance, Congress could remind the courts of ERISA's teeth and forbid employers from asserting termination rights that aren't disclosed in compliance with the statute's requirements. Similarly, Congress could remind federal courts that their mandate to fashion a common law of employee benefits is a serious one which should embrace the progressive doctrines state courts were developing on the eve of ERISA's enactment.

So long as health care costs in our society continue to increase at a far greater rate than other segments of the economy, the pressure by employers to limit their expenses by reducing retiree health care benefits—regardless of the legalities—will continue. Congress must enact meaningful health care cost containment legislation if retirees are to receive the benefits promised them by their employers.

Congress must also refrain from further eroding the benefits provided under Medicare. As already noted, the carve-out nature of most retiree insurance programs means that Medicare reductions in many instances serve only to shift retiree health care costs from the federal government to the private sector. It is imperative that Congress keep in mind that cost-shifting is not cost-savings. The United Steelworkers of America joins with the AFL-CIO and others in urging Congress to give prompt consideration to the Kennedy-Gephardt Medicare reform proposals as a means of solving the Medicare cost problem.

As a labor union, the United Steelworkers of America is prepared to do its part. We will continue to work jointly with employers to contain health care costs in ways which do not jeopardize the ability of our retired members to receive the quality health care benefits which their Union negotiated on their and their dependents' behalf.

These problems are difficult ones to be sure. As a society committed to affording our senior citizens the opportunity to enjoy a retirement filled with dignity and self-respect, however, we have no choice but to succeed.

Mr. ROYBAL. Thank you, Mr. Lynch.

The Chair now recognizes Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK

Mr. GOLDBECK. Thank you very much, sir. I am Willis Goldbeck from the Washington Business Group on Health. It's an organization for the health policy and cost management interests of major employers.

Indeed, there is a problem that it would be irresponsible to deny as well as politically imprudent. We are dealing with the realities of compensation contracts. There is a part of the resolution of this issue which must be addressed through appropriate litigation.

But fortunately, we are not looking at a major national trend. I think that's very important to underline. As bad as the problems are for any individual in this room—and there is no denying that—the reality is that in the last 5 years the average Fortune 500 company has considerably increased its medical benefits for retirees. There are still other problems that need to be addressed—there is no denying that—but the trends have been, by and large, in the right direction.

It is also true that this has taken place despite the recession, despite the change in the ratio of the number of active workers to retirees dropping from 10 to 7 to 2 to 1 and, in some cases now, minus 1 to 1. At the same time, there are, percentagewise, very few big users within the retiree work force. Less than 2 percent ever use more than $10,000 of care in a given year.

The issues go way beyond just medical care and its costs. We are dealing, as Mr. Lynch very accurately depicted, with the problem

of shifting. The reduced commitment in Medicare becomes, in effect, increased commitment among private employers and unions. We are dealing with the problems of certain changing industries. The International Trade Commission's rulings recently in terms of steel point to the fact that there are many more problems concerned with retirement issues and the growth of the retirement population than will ever be addressed simply through medical care cost management.

We will also have to face the fact that we are dealing with a problem of retirement. Retirees are a segment of the population for which we will not have adequate resources in this country. We are not in a position now, or for any time in the forseeable future, to fund the retirement and health benefits for people who will be out of work from 20 to 40 years. That is not what the concepts of retirement, social security, and medicare were conceived for.

Generic to the resolution of this issue is doing something about the changing nature of work in America. Connected to that is the problem of education and the fact that general education does not relate to retraining.

I say that because I think it's important, considering the very critical attention your committee is providing this issue, that it not be viewed only as one of medical care insurance, but as part of a larger set of issues.

Certainly from the standpoint of employers, cost management is a critical factor in resolving these problems. It's equally true for the problems of the expenditures of the employees themselves. Right now in the United States, some 40 percent of all workers are 40 years of age or older. The pressures on future retirement, particularly if we continue to operate under the concept that retirement begins in the early fifties, are going to make today's problems seem like kid's stuff.

There are a variety of legislative issues and potential solutions, or at least progress that can be made. Medicare could become designed for the elderly. That would be a dramatic change. It could include catastrophic coverage. That would certainly be a dramatic change.

The problems that a Mr. Anderson deals with, losing benefits while waiting for the litigation to be completed to determine whether it was appropriate to lose them or not, could be resolved with the provision of State pools that would take place for anybody who is in a litigatory situation.

We also see that the Congress right now is facing several legislative issues that would provide help in the cost management struggles, albeit not total relief from these dramatic problems you're hearing about today.

There is the possibility of getting a handle on malpractice and all the defensive medicine and wasted dollars that are inherent in those problems, through proposals such as the Gephart-Moore bill. The same would be true if the Congress would pass the Wyden Amendment to H.R. 5602, so that there would be full disclosure, hospital-specific disclosure, of comparative price and utilization information so retirees, unions, and employers could provide guidance as to where the most medically cost-efficient and excellent

centers of care are so that we do not waste the precious dollars that we have designated for this category.

Beyond that, though, there are several other kinds of solutions which I think are appropriate, at least to explore. In our organization we have an institute called the Institute on Aging, Work, and Health. Within that we have now established a new project called "The Retiree Protection Project", recognizing the significance of these issues. That's going to be a 3-year program that will attempt, among other things, to build the data base which you, Mr. Chairman, requested in your letter, and will take on several other projects.

The first of these is a project to consider benefit redesign and financing reform. One of the critical issues is to find out how we can develop a portable benefit package, at least for critical care coverage, so that when a person is caught in the trap of a merger, these realignments that you hear about, which create the cracks in the system that we hear people are falling through, the benefit can move with them rather than remaining with an institution. And if not the whole benefit, at least some component of it to protect them against catastrophic expenditures.

Support for the development of the social HMO program, so that finally we begin to have a long-term care finance program in America.

If we are going to design prefunded liability, and that is a perfectly responsible thing to explore, it must be done in such a way that it does not provide an incentive for employers to stop the benefits that we're trying to prefund. It may be that the way to begin that process is to design the prefunding of the catastrohpic component or major medical, if you prefer, in private sector terms, so that again you are prefunding and providing a guarantee for the retention of at least the crisis care, major dollar benefit.

I doubt if we will ever get to the point where we prefund everything so that there will be no deductible, and nobody will have any financial responsibilities at all. Nor do I think that most employers would think that that was a responsible thing to do.

The second component of this retiree project will be savings enhancement. The design of long-term care or other medical care IRA sorts of programs, so that people who wish to can have an employer-contributed IRA system to advance their savings approach for later years.

Also, we would suggest that we begin the investigation of what one might call benefit value exchange. There are a great many employees who never consume, for instance, all of their vacation pay benefits. They lose those benefits after a certain amount of unused time. The same is true of sick leave and a number of other accounted-for benefits. Well, one could assign those if you had a value-related process. You could assign a value to x amount of vacation time and transfer unused value into their retirement medical account, thus increasing the asset, or if you will, the savings of such an account.

Finally, within that savings area, we need to consider the fact that some 80 percent of the long-term care in American today is provided by families and friends, not by the medical care system, not by medicare, indeed, not paid for by anybody. We need to be

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able to enhance this. One of the ways to do that would be to develop kinship tax credits that would provide respite care within the hospice program, something that was dropped out at the last minute when Congress passed the hospice program approximately a year and a half ago.

As a major component of these programs and reforms, we suggest that it is essential to develop a focus on prevention. This is not something for which the elderly are, "too late." We now know, from looking at epidemiology that people in their fifties, indeed in their sixties, if they do stop smoking, can become clean within a period of less than 10 years, to the same extent as one who never smoked before.

We know similar benefits can be accrued from changes in diet, from exercise, from stress management, from the hypertension control you heard about at the other end of the table. These are not programs for young workers only. They're programs for all people. We know they can work.

The medicare program itself could begin to establish a premedicare prevention program, starting, for example, and you can research this in greater detail, 10 years before the normal medicare crisis intervention acute care program, so that everybody who is eligible for medicare will have had available to them for a period of time an array of appropriate well-designed and managed prevention programs.

As you grapple with these issues, I would urge that we consider the extent of the problems for the future which we must recognize, something which neither business nor Congress feel very comfortable doing.

But today's 29-year-old female worker, if she lives a normal lifespan, and if for the first time in history there is no more improvement in longevity, will be alive in the year 2033 and wondering what happened to her benefits. That is the scope of the average future which we must collectively consider in the private and public sector.

In 1870, 80 percent of those over 65 were in the work force. In 1980 that was down to 19 percent, despite the fact that there is absolute consistency in survey after survey that the elderly, or at least those over 65, increasingly don't consider themselves elderly and want to work, want to be contributors to society. By 2010 we will be up, again, to 50 percent, or we will have no benefits. That is an absolute fact. But we don't know how to deal with it.

Let me close by urging you to recognize that this is an issue which we must approach with the public and private sector together. This cannot be something that is done for medicare patients only or for unionized workers only or for hourly workers only. This is truly a societal problem and one which, thanks to your leadership now, we can get a handle on relatively early if we work together. Thank you, sir.

[The prepared statement of Mr. Goldbeck follows:]

PREPARED STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

A COMMITMENT AT RISK

My reply to this rhetorical question has to be, yes. However, contrary to what many may infer, I would suggest to you that the major causal factors are far more important and complex than the rare case of a callous or irresponsible employer.

As a matter of national policy, we have reduced our commitment to the elderly. For the past 4 years, the Medicare coverage has been reduced by an average of nearly 18 percent per year. The so-called "down payment" on the Federal deficit was based, just last week, on a further $11 billion cut in Medicare.

By comparison, during the same period, the extent and quality of corporate health benefits for retirees has been improving. Some of this is because the companies feel a need to do so, having recognized the positive relationship between the productivity of active workers and the quality of retirement plans. Another cause is the cost shifting from Government reductions in Medicare and the new law to make employers the primary payer for workers age 65–69 and first year End Stage Renal Disease Program users.

Whatever the cause, the record is clear. Despite the recent recession, despite the cost shifting, despite the increases in medical care costs, despite the vastly increased number of retirees, the typical major U.S. employer has expanded their medical benefits for retirees.

Mr. Chairman, the problems you heard today are real, complex, deserving of compassion and, in some cases, the result of questionable employer and union conduct. Nonetheless, it is essential that your committee understand that these problems represent the opposite of the trends in retiree medical benefits.

We have a choice. Either we continue to consider the aging of our population as a major national problem, or we recognize our longevity progress for what it is: the greatest accomplishment of our society.

Let me state clearly that, unless we adopt the latter attitude and turn aging from a liability to an asset, the U.S. economy has little chance to maintain its significant position in the world.

This is not to suggest that how we deal with "old people," much less their medical care, is the paramount issue on today's political or economic agenda. Rather, I do mean that the reordering of our demographics is central to the long term reordering of education, employment, family composition, transportation and housing patterns, medical care consumption, savings, and our political values. All are tied to the decisions made by or on behalf of those in middle age or beyond. In fact, middle age, 45–55, is becoming just that: the midpoint in a life that has no biological reason not to extend to 90 or 100 years. As a nation, we are not well equipped to cope with the magnitude of change that is connected to aging.

Due to the attention drawn to medical care costs, their impact on employers and the pending Medicare deficit, it is in the arena of medical and health policy that the economics of our aging population will have its first severe political test.

How ironic that, at the very time when our Nation's economic problems and industrial decline are the focus of world attention, we find ourselves called upon to devise strategies for slowing one of our few growth industries. By every standard of economic growth, the health care industry is a raging success. Unfortunately, that success has been based on a whole series of faulty economic principles, ignorance, and myths. Further, we must change our definition of success or else the failures of the past will preclude achievement of the wonderful future we all want to share. Success must be predicated on how well we prevent the need for medical care, not how much we invest in future cures; how well we advance the quality of life, not just how much we increase life expectancy.

As president of the Washington Business Group on Health, it is my responsibility to examine health in America from the perspective of the very large employer. Our members purchase care in amounts that stagger the imagination as their benefit plans annualy provide for nearly 50,000,000 employees, retirees and dependents. However, it would be wrong to proceed under the assumption that, in the health care economic debate, there need be public versus private sector; management versus labor; provider versus consumer. Only by recognizing the mutuality of our long term interest will responsible programs be possible.

Progress is not served when the Federal Government claims savings that in fact are nothing more than shifts in cost to other payers or increases in proverty for which future Congresses will be held financially and politically accountable.

Progress is not served if large employers act only to protect this year's botton line and forget that their profits are ultimately dependent upon communities that are economically viable as a whole.

Progress is not served by tax policies which reward the largest companies for adding to rich benefits and also reward small employers for not providing benefits at all.

Progress is not served by unions that fight for the preservation of benefits, which we know today are poorly designed, economically wasteful and popular only because of the misconception that there is a positive relationship between the most expensive hospital care and high quality care.

Progress is not served when providers pretend they are the only ones with a right to comparative information or that somehow their industry should not be subject to the same requirements of both economic competition and government regulation as the rest of our industrial sectors.

A PROGRESSIVE AGENDA

There is no simple solution to the problems of retirees who, today, lose expected benefits. Fortunately, these cases are very rare and are one of the very smallest access to care problems now facing the nation.

However, there is much that can be done to prevent the isolated cases you hear of today from becoming a national crisis in a few years.

On the most macro level, we must first accept the harsh fact that no nation can financially support a retirement system that covers people for 20 to 40 years. Therefore, part of the solution must be a restructuring of the patterns of education and work; new definitions of career; and much greater attention paid to the changing nature of work itself.

Recognizing that those topics are too broad for this hearing's agenda, let me focus on a series of actions which can be started immediately and which speak specifically to the retiree medical care benefit issue.

As an organization, we believe this "progressive agenda" to be of such importance that we have initiated the Retiree Protection Project within the WBGH Institute on Aging, Work and Health. This project will continue for the next 3 years, will have as its sole objective the design, analysis, advocacy and evalution of positive approaches to protecting the health and financial condition of retirees and their families. Our project will be open to prticipation by other business organizations, senior organizations, interested unions, and public sector and non-profit sector employers. All our work will be made available to your committee, other congressional committees and the appropriate executive branch agencies.

Our Retiree Protection Project will structure its development of a positive agenda around these themes: (1) Benefit design and financing; (2) Saving enhancement; (3) Prevention.

In each case we will seek the most appropriate mix of public and private sector responsibility. Regulatory and legislative recommendations will be accompanied by an equal emphasis on creative employer and union programs. Retiree self-responsibility will receive its share of attention with the caveat that this not be a mere shifting of costs or blaming of the victim for unhealthy behavior. Instead, we will be working to assist the type of self-responsibility which enhances self-determination and economic independence.

Several key topics in each theme are already on our agenda.

1. Benefit design and financing reform

a. Support for the Social HMO experiments in long term care;

b. Expansion of hospice benefits;

c. Studys of methods for benefit portability, at least for a standardized catastrophic benefit;

d. Designing financial incentives for subacute alcohol treatment programs;

e. Consideration of redefining family to include kinship so more elderly can remain at home yet have financial support for the custodial services which would be reimbursed if they were hospitalized;

f. Developing alternative methods of drug purchase, distribution and monitoring;

g. Assessing the impact of prefunded liability options; and

h. Evaluation of HMO and managed care programs for the elderly.

2. Savings enhancement

a. Applying the IRA concept to the medical needs of retirees;

b. Flexible spending accounts and cafeteria plans specific to the diverse needs of the elderly;

c. Benefit value exchange. For example, if employees do not use vacation or sick leave, the value could be transferred to their retirement account rather than being lost; and

d. Kinship tax credits so that anyone who provides at-home assistance for the elderly and is not paid for doing so can receive tax credits on a predetermined schedule. This would restore the respite support concept to the hospice program and recognizes that the retiree is not the only one for which savings enhancement will be important.

3. Prevention

a. Develop a prevention program for Medicare that begins ten years before the regular Medicare benefits. Thus, at 55 the prevention support program would begin. If people were unwilling to participate at all, their Medicare benefit would be reduced through higher deductibles and copayments. The reverse, an incentive approach, could also be used.

b. Establish a special task force on mental wellness programs for the elderly; and

c. Develop employer and union managed wise buyer programs that make available to the retiree information that compares hospitals, outpatient facilities, home care programs and physicians by service, utilization, quality indicators and price. This represents a commitment to the concept that part of prevention is the avoidance of unnecessary medical care and the ability to obtain the care that is needed from the most economically efficient centers of medical excellence. This cannot be achieved without comparative information.

As we progress, the list will lengthen and be refined. We welcome any suggestions Committee staff may have on ways to improve this modest effort.

COST MANAGEMENT

You hear about the need for cost management and the potential an aggressive strategy holds for reducing waste, waste that is expensive in human as well as financial terms. The essence of cost management is the integration of utilization control, reimbursement reform and capacity controls achieved by a balance of competition and regulation. Cost management does not imply taking benefits away. Rather, it is predicated upon providing guarantees of care in the most efficient setting from the appropriate level of professional care giver. Cost management means employers providing employees and retirees with the information so they can compare providers and the economic incentives to make a prudent selection.

A few examples of available opportunity may be helpful.

1. The St. Louis Coalition initiated a utilization review program which, at a cost of $450,000, produced a $5,000,000 savings in just 1 year.

2. The Delaware PSRO notified just two physicians that their practice patterns were inconsistent with standards of efficiency. Just notification, no penalties, produced a saving of 1,364 hospital days or $545,600. The same PSRO has used its precertification program to reduce admission rates by more than 60 percent.

3. LTV and the Texas Medical Foundation have combined in a program that makes reimbursement contingent upon the use of outpatient facilities if they are available. Admissions per 1,000 dropped from an already low 450 to 190 and the cost per admission fell by 30 percent.

4. Two pack a day smokers, age 35 to 44, experience medical expenditures and lost wages $20,000 for females and $59,000 for males above the average for nonsmokers of the same age.

5. The Quaker Oats flexible spending account, in its first year, resulted in a saving of $210 per employee.

6. Fund saves more than $500 for every employee who enrolls in an HMO rather than using insurance.

7. Deere & Company reduced its utilization by more than 30 percent in Iowa and Illinois in just 4 years.

8. A new study has shown that if geriatric patients received drug prescriptions from clinical pharmacists, rather than a doctor, they could save $70,000 per year per 100 skilled nursing beds while achieving fewer deaths, reduced drug per patient, fewer patients hospitalized, and more patients discharged to lower levels of care.

The few examples serve merely to show the vast room which exists to save money through systems reform rather than benefit reductions that would threaten the security of retirees.

PREPAYMENT AND NEGOTIATING FOR CARE

One of the most dramatic shifts in medical care financing is the move away from insurance policies to negotiated plans in which the employer or government agency buys a package of care for a predetermined price.

HMOs represent the best known and most advanced aspect of this movement. Although nearly 60 years old, HMO's have not traditionally viewed the elderly as a desirable market. Changes in the Medicare law, several Medicare-HMO experiments, and increasing competition among doctors and hospitals have led to a rapid growth in HMO enrollment for those over 65. Minneapolis, long a center of HMO development, offers a clear example of this growth. According to the Minnesota Department of Health:

ENROLLMENT OF THOSE 65 AND ABOVE BY YEAR

HMO	1980	1981	1982	1983	1984
HMO Minnesota	0	461	840	2,776	4,100
Medcenters	0	1,360	3,222	4,874	6,852
Share	722	5,825	12,514	18,577	26,000
Physician's Health Plan	0	888	1,533	4,482	7,500
Total	722	8,534	17,629	31,109	44,552

A more recent development is called the PPO, preferred provider organization. Other names are designated providers or negotiated provider agreement. Regardless of name, the concept is the same. The purchaser (employers, unions or government programs) reach agreement with either a provider organization (doctors or hospitals) or with an intermediary for a selected amount of care at set rates which are below those paid by insurance. In theory, the purchaser benefits by having selected the most efficient providers and being charged less than before while the providers gain through increased volume and certain payment. In turn, the purchaser provides strong economic incentives to have the workers, or Medicare recipients, go to the providers with whom the contract was signed.

For the elderly, assuring the prepaid and negotiated care systems are of high quality and efficiency takes on greater significance with each new Medicare deductible and benefit reduction. As Medicare moves to adopt a voucher system, it is essential that there be a full range of alternative delivery systems among which to shop for care. HMO–PPO systems offer the greatest financial protection and greatest opportunity to provide the home care, custodial service, prevention, social service and other chronic care benefits that are so typically excluded in Medicare insurance.

The traditional concerns that have hindered the acceptance of HMO type programs by older Americans are being diminished by a combination of factors. HMO's in general have an excellent medical and financial track record. Those that have served the elderly have proven they could do so with fine service and very large savings. There is a rapidly decreasing portion of the elderly population which has a family doctor or for whom the doctor they do know is suited for the medical needs of their later years. Competition among doctors and economic pressures on hospitals have considerably expanded the number and variety of prepaid and negotiated plans. Finally, fear of financial disaster due to the low level of Medicare coverage has helped make the HMO option increasingly attractive.

A combination of economic, demographic and political forces appears to be converging with sufficient power that it is quite reasonable to predict that Medicare will have only HMO-type options by the end of this century . . . only 16 years away. This may be the only way to turn the inevitability of an increasingly two class system of medical care into an advantage for the elderly.

HEALTHY AGING

Increasingly, employers are accepting the need to help employers avoid the chronic and degenerative illnesses that today characterize the health status of the elderly. This is not a naive avoidance of the obvious truth that death is inevitable nor of the harsh reality that rarely is death as quick as we would all like. On the contrary, the concept of healthy aging marks a changing attitude, a new consciousness that there is no biological imperative for the human animal to evidence dramatic physical deterioration coincidental with either reaching age 65 or retiring from work.

Healthy aging is an affirmation that growing old can be a chronological progress to be honored, not a medical problem to be treated. Employers such as IBM, Weyerhaeuser, American Express, Champion International, Deere & Company, and Owens-Illinois—to mention a few—are including retirees in their wellness programs. Others are expanding traditional pre-retirement planning programs to include life style enhancement and risk reduction education.

In addition, the field of health promotion has discovered the elderly market. For years, innovators like Ken Dychtwald have been demonstrating that there is no age at which wellness cannot prove beneficial. Authorities such as Jonathan Fielding have presented the epidemiological evidence that shows the positive impact of, for example, smoking cessation or hypertension control even for those of advanced years. Only recently have the purveyors of wellness programs begun to vigorously pursue the elder market.

Creative projects, like the Healthwise Growing Younger program, are proving effective and replicable. That the potential for these programs is enormous can be demonstrated by just two startling facts.

A. The percentage of U.S. males, age 18 to 22, killed in World War II who, upon autopsy, were discovered to have signs of atherosclerosis was too small to measure statistically. The same study done on those killed in the Vietnam War found greater than 95 percent with evidence of atherosclerosis.

B. In 1978, the Office of Technology Assessment found that coronary artery bypass surgery is performed in the United States at a rate of 483 per 1 million population. This is more than double the combined rate for France, England, West Germany, the Netherlands, and Sweden.

Put simply, unless we make a major investment in prevention we are guaranteed to become increasingly mired in otherwise unnecessary medial care, care we will not be able to afford to guarantee for elderly Americans.

2000 AND BEYOND

All our efforts to strike a balance between expenditures and access, laudable and necessary as they are, will fail unless the characteristics of our society, our technology and our place in the world are given due consideration.

The year 2000 is no further away than a new baby's junior year in high school. Today's 29 year old woman will achieve today's standard of life expectancy in 2033 * * * and that presumes no further progress in longevity. By then the Major global health issues of water, food distribution, nutrition, the environment and hazardous waste will be far more significant for the United States than they are today. If we have not redistributed the entire planet throughout the universe, we will have even more compelling social needs competing with medical care for finite resources.

Our world will have expanded considerably beyond our lerth with untold health consequences. Few if any domestic social issues will be as heavily impacted by our incursions into space as will human health. As this chapter is being written, United States and Soviet scientific teams are hard at work hundreds of miles above this planet. The foremost commercial and peaceful use of the space shuttle, and subsequently of space stations, is pharmaceutical development predicted upon otherwise unattainable chemical separations and interactions. A high priority for new drug development is the elimination of Alzheimer's disease.

One of the reasons we have today's cost problems is that, in the past, we tried to treat medical care as though it was isolated from the rest of our social and economic needs. Rarely have we ever taken a dispassionate, comprehensive view of our medical needs.

If we had done so, research into the prevention and cure of cardiovascular problems would receive approximatley ten times the resources as those devoted to cancer, yet the reverse is true because the cancer lobby has been more effective than their heart disease counterparts.

If we had done so, mental health, dealing as it does with humankind's most intricate and vital instrument, would not be the financially weakest element of medical care reimbursement.

If we had done so, we would not have based Medicare on an acute care hospital model, much less been surprised at the rapidly growing older population.

A strategy for the future cannot afford to ignore either these larger world issues or the lessons from our domestic past. Our family structure is no logner the nuclear stereotype; the classic family doctor is a rarity; everyone will have access to their medical records and massive banks of self-care data via telecommunication * * * at home; medical professionals will have instant access to the latest techniques, best research, total medical history regardless of where records may be located; diagnosis

will be increasingly dependent on electronic implants that warn of pending problems as well as correctly pinpointing the cause of crises; compliance with drug regimens will not be an issue as time release capacity is extended to 12 months and beyond. These factors, combined with parts replacement, elimination or control of many emotional disorders and the as yet largely untapped potential of diet and psychological control of disease, represent a world that we will not avoid yet are ill prepared to enter. Unless the work we do to address medical care costs in 1984 at least considers the future we can guarantee only one result: more expensive problems that could have been avoided or ameliorated.

CONCLUSION

If we fail to restructure medical economics, we will threaten not only the opportunities for improved health status and access to medical care but also the total economic viability of our country. We cannot allow a trillion dollar Medicare deficit or employers placed at a competitive disadvantage in the international marketplace due to premium increases.

Balance in the division of responsibility between the public and private sectors is essential. Employers need to understand that they cannot avoid the costs of care and that all trends in global economics, demography and domestic politics are increasing the scope of corporate responsibility for social services. Government, on the other hand, does not improve the overall economy or even medical economics by shifting costs, increasing the number of persons without program eligibility or decreasing our already meager commitment to health care services research.

Balance must be achieved between the exigencies of economic pressures and the ethics by which the true value of a society is measured. No longer is ethics the arcane province of academics and philosophers. Death with dignity, organ acquisition, right-to-life and the rationing of new technology are now the language of daily headlines and high school discussions.

The economic resources we now waste on medical care threaten not just the competitive viability of our members, nor only the budgets of countless State and local governments. Significantly, this waste threatens the destruction of the very industry it now supports. With that destruction would come an end to America's pre-eminent position of medical excellence; a drastic reduction in the employment of millions of minority and female workers; greatly increased rationing by wealth; and no chance for the investment in prevention that holds such promise for future generations.

We must work together to prevent this unwanted and unwarranted destruction. We can have a competitive system which rewards centers of efficient excellence and protects, through appropriate regulation, the right of access to needed care for all Americans.

Mr. ROYBAL. Thank you, Mr. Goldbeck.

The Chair would now like to recognize the presence of the gentleman from Pennsylvania, Mr. Murphy. He is not a member of this committee. We, of course, welcome him this afternoon. It's my understanding that Reverend Garner is his constituent, and the Chair now recognizes the gentleman from Pennsylvania, Mr. Murphy.

STATEMENT OF REPRESENTATIVE AUSTIN J. MURPHY

Mr. MURPHY. Thank you, Mr. Chairman. I do appreciate your courtesy in allowing me to sit in. I am sorry I missed the opening, and especially Reverend Garner's testimony. I have met with their ALIVE coalition and they are doing a tremendous job. So, I anxiously await your cross examination of the witnesses.

Mr. ROYBAL. Thank you, sir. May I say at this time that the Reverend Garner has provided this committee with some testimony. We are going to question him, however, about some of the things that he has said.

May I, then, proceed in the regular order, trying to at all times stay within the 5-minute limit? We will question each one of you for 5 minutes, that is each member of the Committee. We can come

back for an additional 5 minutes and stay here until it is necessary to get as much information as we possibly can.

But first of all, I'd like to start my questioning with Mr. Gajda. I think that your testimony is not only interesting but it hits at the crux of the matter. We realize that the results have already been presented by Mr. Anderson and Ms. Nickelson. But you did state that retiree medical plans should be pre-funded. Will you expand on that? Can you tell the committee what has happened in the past? Why is it that these companies are in the predicament that they are now, where they are telling these individuals we can no longer continue funding your medical plan? Was it because they did not pre-fund it?

Mr. GAJDA. In part. In part that's the reason.

Mr. ROYBAL. All right, tell us, give us the full story.

Mr. GAJDA. I am going to restate the question again. Why have firms not pre-funded, and why are firms in trouble today, and would pre-funding have saved them from that trouble? The answer is probably yes and no, and that's not a cop-out. What it means is that their costs today are emerging on a pay as you go basis. In other words, they are being paid as the retirees begin to claim benefits. Nothing has been set aside, as Don Fuerst mentioned before, so that there will be some assets to pay these benefits when the retirees start to claim them. If we look at the businesses or the firms of the industries that are particularly suffering these problems, I guess you could generalize by calling them the smokestack industries, the popular term these days, industries where the work forces today are much smaller than they were 5 or 10 or '5 years ago, and where the pension plans have matured and the number of retirees, in some instances, actually exceeds the number of active employees.

So that since there have been no moneys set aside over time to pay for these benefits, the fact that the active employees have fallen, the retirees have increased, and we have this hyper inflation in health care prices, and we have some of the shifts from medicare, we have all these forces coming together and creating situations where retiree costs actually exceed active employee costs. If these plans had been pre-funded, the problems would be smaller today. But it would have been difficult, if not impossible, to anticipate contraction of industries and the effects that those contractions of work forces would have had on pre-funding. It would have created another problem. It would have created deficits in the funding levels of these benefits.

If we had to say it in a sentence, pre-funding is better than no funding. Pre-funding permits the accumulation of assets with a constant annual cost and not an exponentially increasing cost each year, and would permit these benefits to be provided without the kinds of shocks that some firms are suffering today and how they pass those shocks on to some of the people sitting at this table.

Mr. ROYBAL. I would like to ask, then, the following question: Would you recommend, then, that the entire health benefits be pre-funded by the action of Congress?

Mr. GAJDA. Well, we would like to see an effort made before legislation is passed. And the next question is, "Well, why hasn't the effort been made?" Probably because the problem is one of recent

vintage, as I said in my opening remarks. We are seeing this kind of problem in a few industries. It's not widespread, as Mr. Goldbeck said, at the end of the table. It doesn't mean it's not going to become widespread. We think that as industries grow, they're going to provide this benefit, and eventually everyone will see that exponential increase in cost.

We think that efforts should made in a variety of forums to encourage firms to look at these kinds of efforts and to look at the potential consequences of funding.

It's possible sometime in the future they may need more encouragement, just information. But for the time being, because it's a recent problem, it's an emerging problem, legislation may surprise them. They may not even be aware that this is a potential problem. But that may have to be the way it went sometime in the future.

Mr. ROYBAL. Well, how long will it take to finally decide that something has to be done with regard to prefunding? You said this is something of a new vintage? How new is it and how long will it take to finally come to the conclusion that perhaps this is one of the things that should be done?

That is only one side of the ledger. The other side, where we find that there's an increasing cost, increasing the cost of medicine, that has been increasing steadily.

Mr. GAJDA. That's right.

Mr. ROYBAL. Well, taking the two together, what can be done about prefunding, and the second point, what recommendations do you have to contain costs?

Mr. GAJDA. Oh, I'm glad you asked the second one.

Mr. ROYBAL. Let's answer the first one first.

Mr. GAJDA. OK.

Mr. ROYBAL. Because I wanted to see what Mr. Fuerst has to say about that and also Mr. Goldbeck.

Mr. GAJDA. What do we suggest on the prefunding? I think, between Don and I, we've got complete agreement here. And that is that any kind of legislation or regulation that requires immediate funding would probably lead to the termination of many, many of these plans because it would be easier to get rid of the problem than to try to cope with some apparently horrendous kinds of cost increase which are going to destroy some price structures in some industries in the country.

We believe that looking at the problem of information first, gathering the information on what these costs are, disclosure, understanding, letting employees know what these costs are, and then; if practical, and we don't say that as a hedge, we mean, if practical, some gradual implementation of funding, over some period of time. That was exactly the last sentence of Don's presentation.

In some instances the cost would be a shock to firms, to prefund this benefit, particularly in the younger firms, a firm that is growing, these new conglomerates. It would be a shock for them to find out what that liability is down the road. So, some kind of gradual implementation, after some considerable thought about how you do this kind of prefunding. Because it's not the same kind of problem as pension. And if that same question is asked of Don Fuerst, he'll elaborate on that.

In terms of controlling costs, health-care costs, I assume that refers to the fifth recommendation that we made but did not discuss, in which we suggest that the health-care costs are a national problem, they affect everybody. They're particularly difficult for the retired and aged, because of their generally lower levels of income.

We in the private sector have been grappling with health-care costs and we think we have to grapple with them because the economy in this country was relatively robust and growing for probably the 15 years after the advent of medicare. And we could absorb cost increases. Nobody liked to do it but it wasn't that difficult to do.

The last two recessions, though, and with the paring of work forces, these costs have won new attention because, while business has grown, it hasn't grown at the same rate these health costs have grown, and it's not unusual today to see instances where health-care costs are $2,000 per employee per year, $3,000, $4,000, even $5,000 or more per year, just for health insurance. And we have probably all seen the stories coming out of General Motors and Chrysler about the impact on the pricing structure of cars and the effect of that on the competitiveness of our auto industry versus the foreigns.

We in the private sector have had to deal with this, to use some economic terms, on a microbasis and not a macrobasis. We deal with this problem with our clients virtually every day, and we've had some signal successes with a whole variety of programs, the most important of which, I guess, we call managed health care. I am not sure that Mr. Lynch has run into this in some of the contracts that he negotiates. But managed health care, I guess in a nutshell, says consumers really should not be allowed to go out and get whatever health care that they want, that there should not be an absolute freedom of choice and almost an encouragement to go out and consume health care, that there are reasonable and efficient levels of health care. By the way, if imposed, those would actually improve the quality of health, not diminish it. It would keep some people out of hospitals where we have what we call the iatrogenic diseases, that you're healthy going in but you catch something in the hospital.

We would keep people out of surgery where there is literally risk of death. We would encourage the same kind of wellness programs that both Mr. Lynch and Mr. Goldbeck recommended. But there are techniques. We have a list of 30, or 40, or 50 of them that we use as a menu when we try to work with a client. And we think some, if not many of those techniques, are available and can be used in programs such as medicare, in the medicaid programs. New York State is starting to move in this direction with its medicaid program. It's not a secret. Some firms have had some very, very important successes with attacking health-care costs through these containment measures, and the singular success is that the employees of those firms are probably receiving a higher quality of health care today than they did before these programs were undertaken.

Mr. ROYBAL. Thank you. My 5 minutes are up. I therefore now would recognize in the order that they came in, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Gajda, going back to the prefunded aspect, how would that be done? Would you say funds would be placed into an escrow type of situation, funds invested into certain safe securities which might appreciate reasonably, that sort of thing? Is that what you envision as prefunding?

Mr. GAJDA. Something on that order. I'm not begging off but Don and I have tried to make a joint presentation and that's his specialty.

Mr. BILIRAKIS. OK. Well, very briefly. I don't want to use my entire 5 minutes on this, although it deserves 5 hours and then some. But very briefly, Don, if you would comment on that.

Mr. FUERST. Yes; thank you, I think that in order to produce real security for the employee, the money has to be segregated into, I would suggest, a trust, which is to be used for the exclusive benefit of the beneficiaries, the employees. Such vehicles do exist today. There is the 501(C)9 trust, which is used for funding welfare benefits plans for employees.

There is also the 501(A) trust, through a pension plan, where medical benefits can be provided to retirees as part of a pension plan. There are also some insurance contracts, which provide particularly life insurance for retirees, which can be used to fund these benefits before the employee actually retires. I think that an expansion of these techniques would be the appropriate method to fund these benefits.

Mr. BILIRAKIS. All right. Now, how would these funds, or the contribution of these funds, if you will, of the employer, be treated by the tax authorities under the current tax laws?

Mr. FUERST. Under the current tax laws I think there has been some question. And that's part of the hesitancy of some employers to fund these expenses in advance. There is the pension trust which has limitations on the level of medical benefits. The medical benefits basically have to be only a minor portion of the total benefit provided, if it can be funded under that. If it does qualify in that respect, then the contribution is deductible. Contributions to a 501(C)9 trust are deductible, if the trust meets all the qualification rules of the code, and there are a few insurance contracts which contributions to are premiums paid to those contracts, and the contributions are deductible.

But there is considerable hesitation or uncertainty about the deductibility of substantial contributions to a 501(C)9 trust, for instance. I understand the conference committee dealt with that issue last week but I haven't seen exactly the outcome of that.

There has been quite a hesitancy and uncertainty as to the deductibility or the accumulation of large reserves or large funds of assets to provide those benefits.

Mr. BILIRAKIS. OK, now, yes or no answer. Would you provide benefits to employers in addition to what may or may not be available now, since we're not sure about the conference bill, to encourage employers to prefund these liabilities, provided the law would not change?

Mr. FUERST. Provide tax benefits, you mean?

Mr. BILIRAKIS. Tax benefits, yes.

Mr. FUERST. Yes; we would strongly support that.

Mr. BILIRAKIS. You would? In the form of tax credits?

Mr. FUERST. Tax credits or tax deductions. But if you draw the analogy to pension plans again, in 1974, when ERISA was passed, which first imposed funding requirements on pension plans, at that time many pension plans were well funded, and companies had been funding pension plans. There certainly were some abuses, which the law dealt with. But the majority of plans were funded and the majority of companies did not have pension expense significantly increased by ERISA, although there was some increase for most.

The reason for that is because prior to ERISA there were substantial incentives for employees to fund pension plans. Those don't exist for medical plans today. There were requirements to expense the pension plan and there were requirements to recognize the expense as deductible, that it had to be funded. Those situations do not exist today for medical plans.

Mr. BILIRAKIS. This deserves so much more time but I wanted to get to Mr. Lynch very quickly.

Mr. Lynch, you stated quite clearly that the Reagan administration has failed to intervene in a single instance to help protect retiree-health-fund benefits. I always hate to hear things like that in these hearings because we should be concerned with the problems, and God knows, we all acknowledge there is a problem here. And we should not be throwing stones. I don't feel we should be doing everything in a positive manner.

And whereas what you have said is basically true, I believe, based on the information I get from staff, I also understand that the Carter administration did not intervene in a single suit of this nature either. Is that true?

Mr. LYNCH. I'm not sure about the Carter administration.

Mr. BILIRAKIS. You're not sure?

Mr. LYNCH. But I am sure that we made a request under this administration which has been unanswered. There is an authority, however, under the law, which does allow the Secretary of Labor to intervene and to help if he chooses to.

Mr. BILIRAKIS. But how long have you been in your current job as vice president of human relations?

Mr. LYNCH. I've been in my current job since 1976, September 2.

Mr. BILIRAKIS. And since that period of time the first cases of this sort have arisen since 1981? Is that correct?

Mr. LYNCH. Well, let me explain to you that since 1981 we had not had the kind of devastation that we have experienced, and layoffs, and plant closures, and people being required to leave their jobs that had enough time to retire with retirement benefits, and having these employers deny those retirement benefits.

Certainly we have, the one previous administration had, on a gradual basis, some operations to go down. But since 1981 we have lost at least 600,000 people that were members of our union and that had some insurance and retirement benefits, and many of those have not been able to realize those benefits because of just recently the decisions not to pay those benefits.

Mr. BILIRAKIS. Have you negotiated any of those contracts for the union?

Mr. LYNCH. Sure. I've been in those negotiations.

Mr. BILIRAKIS. You personally have?

Mr. LYNCH. Yes.

Mr. BILIRAKIS. Did you require prefunding, in your contracts with the employers? Could you not have foreseen that something like this may have happened, particularly since we're talking about smokestack industries, particularly since it's been forecast for many, many years that there would have to be modernization and that sort of thing? Did the unions never consider that this sort of thing might happen in the near future, and consequently try to defend for it by requiring some sort of system of prefunding?

Now, I know of what you speak, sir. Even though I represent people in Florida now, I'm originally from Clairton, PA, near Midland, in those areas. And I have relatives and friends and every time I visit Pittsburgh, which is often, I make it a point to go there to see the depredation in that community. And it's a terrible situation and I agree with you there.

But I am wondering where were the labor unions back when the people really needed them, during the time of negotiations of these things? And I ask that question right up.

Mr. LYNCH. OK. I'll answer you right up, sir. The labor unions were there asking for these benefits in our proposals, and as you know, what we ultimately end up with in contracts is what both parties agree to. Unfortunately, we were not able to persuade many of those managements to enter into those kinds of agreements across the bargaining table.

Of course we never foresaw the kind of cyclical downturns that occurred within the last 3½, 4 years. We never anticipated that we would be facing the situation with people, with retirement rights and retirement benefits, having no job to report to. That was never anything, I don't think, that anybody foresaw. So, as a result of that, of course we did not put that as the major and top priority in collective bargaining.

However, it was certainly considered and we do have, we think, some substantial protections in our collective bargaining agreements, particularly in the industries that have the kinds of finances, and we were able to get those kind of agreements.

Mr. BILIRAKIS. Is my time up, Mr. Chairman? I suppose it must be. I thank you, sir.

Mr. ROYBAL. Thank you.

Mr. BILIRAKIS. Thank you, Mr. Lynch and Mr. Gajda and Mr. Fuerst.

Mr. ROYBAL. The Chair now recognizes Mr. Ridge.

Mr. RIDGE. Thank you, Mr. Chairman.

Mr. Anderson, did the contract between your union and the Bessemer Cement Co. provide specifically for health insurance benefits during retirement for all employees? Is there specific contractual language?

Mr. ANDERSON. Yes; it's very clear in the contract, that all retirees would get pension for life, and hospitalization.

Mr. RIDGE. All right. Mrs. Nickelson, speaking about your grandfather, the retiree from the Alpha Portland Cement Co., it is my understanding of your testimony also that there was specific contractual language providing for these kinds of benefits for your grandfather upon his retirement.

Mrs. NICKELSON. Yes, sir; and I can read you an excerpt from that. It says:

"Future retirees' life insurance increased from 2,000 to 2,500 hours, company will pay full cost of all group insurance for them and their dependents until death of the retiree.

Mr. RIDGE. Reverend Garner, likewise, I think you mentioned you had some documents with you from industry basically—is the language similar to that as reported by Mr. Anderson and Mrs. Nickelson?

Reverend GARNER. Yes and no.

Mr. RIDGE. All right.

Reverend GARNER. And I'll tell you why I say that.

Mr. RIDGE. We're used to those kind of answers.

Reverend GARNER. Yes; I know. I'm used to giving them, so that's OK.

Mr. RIDGE. Don't worry about that.

Reverend GARNER. My profession has very few absolutes sometimes. I mean organizing, not ministering.

There are really four elements, as I shared earlier. I do have some documents I can submit.

Mr. RIDGE. I was going to ask the chairman, with unanimous consent that the witnesses who have testified as to the specific contractual language be given the opportunity to present that as part of the record so we can have as part of the record the agreements between the unions and management that made these promises. I think it would be very helpful.

Mr. ROYBAL. Without objection, it will be the order.

Mr. RIDGE. Thank you. I don't mean to cut you off, Reverend.

Reverend GARNER. That's OK.

The book actually outlining the pension benefits, which is this handbook handed out to each individual pensioner does include a clause that says:

The pensioner's and surviving spouses' health insurance agreement, continues until December 31, 1983, and thereafter, subject to negotiations between the company and the union, which may take place no earlier than 1983.

I assure it is the ambiguity in this statement which leads Colt to believe they have found a loophole.

But I need to comment further, and this perhaps relates to the question that was asked Mr. Lynch. There are really three other elements. The first is the 1977 steel settlement. So, yes, they actually did realize this before 1981. On page 22 of the settlement it states in the context of plant shutdowns, that the intention of this settlement in the negotiation of a lifetime security program for employees in the steel industry—a lifetime security program. That does include the health insurance benefits.

The clear intention of their settlement in 1977, in the context of plant shutdowns, was lifetime security. So there was foresight in that.

Mr. RIDGE. Is that in the specific contractual language between the steelworkers and the steel industry, that this contract is to provide that?

Reverend GARNER. Yes; it is in the steel settlement that I have.

Mr. RIDGE. Fine. Will you be presenting that as well?

Reverend GARNER. Yes; I will.

Mr. RIDGE. Thank you.

Reverend GARNER. The other factor is that at the exit interview given to these individuals it was promised in full for life. This is a key part of the four elements, and I can share this also for the record. If you add them all together there's really no question.

Mr. RIDGE. Thank you.

Mr. Goldbeck, there has been some reference that because of changes in the medicare system during the past several years that there has been an added burden thrown at the private sector to be picked up either by the employer or by the employees. In your capacity as president of the Washington Business Group, have you had an opportunity to actually quantify that? In other words, as a result or consequences of these changes in the medicare program, employers and employees are now paying *x* number of dollars more for retirement benefits, retirement health benefits, than they would have before. Have you had an opportunity to quantify that?

Mr. GOLDBECK. Let me answer that this way sir: The changes fall into three specific categories. No. 1 was the change in the law that made employers responsible to be the primary payer for workers aged 65 through 69, so in that case they went from being supplement to medicare to being primary to medicare.

Point 2: In the end stage renal disease program, employers were required to pay for the cost of the first year of the utilization of the renal disease treatments, after which it would revert to medicare, rather than starting with medicare. So, those costs were the direct total costs of whatever had been before.

The third is somewhat more amorphous, but you can get a handle on it by looking at, on the one hand, the rate of increase in the deductibles for medicare, deductibles and copayments together, which on average the last 4 years have been 17.9 percent increase per year, and that does not include the increase which you just negotiated as part of the so-called downpayment on the deficit. That $11 billion worth of changes is not in, yet, the average 17.9 percent to which I just referred.

And, on the other hand, looking at the employer's contracts, which are often referred to as medicare supplemental or "wrap-around" kinds of insurance policies.

For many of the big Fortune-500 companies, those policies, in simple English, as opposed to insurance-ese, say, "We will pay what medicare does not pay." There may be various subtleties of limitations thrown in of lifetime amount and things of that nature. But in essence what medicare doesn't pay, the employer pays. Those are equally true, by the way, for negotiated union-related plans and nonunion plans.

Thus, when you have, in a given year, a 17.9-percent reduction in medicare, there is virtually automatically a 17.9-percent increase in the employer's cost. Now, that would obviously vary by use from company to company. Sun Oil has 9,000 retirees, Digital has 350 retirees. It depends on where they are in their histories. Heaven only knows what Bethlehem Steel has or United States Steel.

But the amount per company is widely variable and is affected by much more than the amount of the increase for medicare itself.

But that gives you a sense of the proportional rates of increase over the last 4 years.

Mr. RIDGE. Thank you, Mr. Goldbeck.

Mr. ROYBAL. The time of the gentleman has expired. The Chair now recognizes Mr. Daub.

Mr. DAUB. Mr. Chairman, thank you very much. May I have permission to have inserted in the record an opening statement at the beginning of the hearing today?

Mr. ROYBAL. Without objection, it will be the order.

Mr. DAUB. And I think Mr. Hammerschmidt would like the same privilege.

Mr. ROYBAL. Without objection.

Mr. DAUB. And any other member—why don't we do that while we're at it?

Mr. ROYBAL. All right. Any other member that wishes to do that can do that at this time.

Mr. DAUB. Thank you.

Mr. Chairman, I spent a long part of my life dealing with employment pension and profit-sharing plans and fixed and defined plans. It's easy to lose sight of the fact that there are two sides to every story, particular these kinds of stories, when you hear such emotional testimony.

I'm glad that we are hearing the personal perspective of some of these witnesses, but I think it's important to get some things straight in the record, so I wanted to ask some questions. First, Mr. Anderson is a plaintiff in pending litigation. Is that true?

Mr. ANDERSON. Right.

Mr. DAUB. And that litigation is against Bessemer Cement Co.?

Mr. ANDERSON. Yes.

Mr. DAUB. And Reverend Garner, you helped organize former employees of Colt who are now in litigation against Colt, is that not right?

Rev. GARNER. Yes, sir.

Mr. DAUB. May I ask of staff or the chairman, whoever may know, have Bessemer and Colt been afforded an opportunity to present their views on these pending cases before this hearing?

Mr. ROYBAL. Well, the truth of the matter is that this is the first of a series of hearings and we hope that we can in future hearings, hear from the other side. The people that are here today actually are not all individuals that can give us the full information. We can do that in other hearings.

Mr. DAUB. Fine, Mr. Chairman. I just want to indicate that since it appears that they have not been requested to appear or submit testimony at this hearing, and because there are two sides to every story, in order for the record to be complete, at this point, may I ask unanimous consent that the record be held open for 30 days and that invitations be sent to Bessemer and Colt for any statement they might wish to make on their own behalf for the record?

Mr. ROYBAL. That would automatically be done if we were not to hold another hearing. We would ask a representative of any company to come forward and testify in future hearings, or can ask for their testimony. I hope they would appear before the committee. That would be a lot better than just testimony.

Mr. DAUB. At any rate, I do ask for unanimous consent that we have the record open for those two to say yes or no to us and submit anything they wish.

Mr. ROYBAL. Well, I have no objection to it.

Mr. DAUB. Thank you very much, Mr. Chairman.

A couple of quick things.

My colleague, Mr. Bilirakis, pointed out something that I think is very telling to the effort that we will undertake as we examine this issue. That point is on page 2 of the news release of the chairman, announcing these hearings. According to recent calculations, Mr. Goldbeck, the present postretirement health care liability of our Nation's 500 largest companies stands at an estimated, staggering $2 trillion. That commitment already pledged by companies represents nearly twice the total net worth of these 500 largest firms.

I think it's very important to understand what happened when we passed ERISA. What happened was that 3,800 companies shut down their pension plans in the first year and a half after Uncle Sam and Big Brother stuck their nose into the private sector. Simply because they didn't want the burden, want the hassle, or because of the overhead that was placed upon them, or fixing of liabilities that the marketplace could not predict so far out into the future, that they didn't want to take the risk that some of the same things you are talking about now might happen.

So, they just stopped offering the coverage. They terminated their plans. Now, with what Congress did in TEFRA in 1982, a whole bunch of other plans, in my judgment, are going to shut down because that law requires them to all be reevaluated, resubmitted, and reapproved. So a whole bunch more companies in America are going to shut down their pension plans and their fixed and defined plans.

I suggest that if we ever take a look at this problem on the medical side and ask Uncle Sam to figure out some ERISA type guarantee, that we're going to see companies start to shut down what they offer, in terms of health and medical benefits to their employees, regardless of whether their employees are unionized or if they've been loyal and performed well.

People are going to want to avoid getting into this problem because of the risk of lawsuits and the Government forcing them to pay when, in some cases, there may be no profits generated in their business to be able to make the payments. These companies may have had bona fide plans from the beginning with every intention to follow through.

I think it's important to be careful. We've got a means test in medicaid. We means tested Social Security last year, when we passed the reform bill, by taxing the earnings of those that make over $25,000 or $32,000, for a married couple. I want everybody to recognize the dilemma that we face. Medicare is expected to be broke by 1991. Medicare has been extended to cover prosthetic devices, eyeglasses, canes, walkers, renal dialysis, respite and hospice care, and pacemakers. Some employees have taken advantage of the fact that the Government pays so much already. Their attitude is, "why should we pay anything in the private sector? Uncle Sam will take care of it." And that's why medicare is going broke. You've got the Government going to shut down their coverage.

It's a very difficult problem to say that the Federal Government ought to intervene to provide a solution, as agonizing and as difficult as it is to face the problems that some of the witnesses have indicated to us today. So, I guess rather than take my time with other questions, I'll just open it up to the panel to comment on the dilemma I have outlined. What does anybody think of that? And I won't ask any more questions.

Mr. GOLDBECK. Since you threw my name in the middle of that, maybe I'll start.

I did, in my prepared text, and in my few verbal remarks, mentioned the concern that you, I think very articulately, just described about the potential of some companies dropping their benefits. I think we do have the possibility, however, of not looking at these issues as total either/or circumstances. Either we demand a prompt payment of $2 trillion or we don't have prefunding.

The prefunding issue is not one which addresses today's retirees. It's very important to have that real clear. That is an issue to consider for a long-term future. And it would be quite possible to design a rational, phased in, prefunding approach, to a defined level of benefits, if that's what was wanted.

Mr. DAUB. Do you want to tax health care benefits?

Mr. GOLDBECK. That isn't what I said.

Mr. DAUB. As income to the employee?

Mr. GOLDBECK. That isn't what I said. That isn't what you asked.

Mr. DAUB. But you're suggesting that, something get paid for even prefunded, that may be tax deductible or a credit or somehow written off by the company or by the employee and all you're going to do is exacerbate the problem if that is going to escape tax.

Mr. GOLDBECK. No, what I was responding to was the suggestion and the question you raised, which was whether or not there was any validity or possibility of dealing with the subject of prefunding. It's another matter if you want to talk about taxation.

Mr. DAUB. But you know that implicit in that is whether or not that is taxed.

Mr. GOLDBECK. That is a basic question that has to be addressed. That's right.

Mr. DAUB. Let's see what Mr. Lynch has to say now, because we don't have a lot of time, the bells have gone off, correct?

Mr. ROYBAL. But the gentleman's time has expired. But we'll let it go as a general question and ask for it in writing.

Mr. DAUB. If you would care to submit in writing on the dilemma we face based upon the two points of view represented by the panel I would most appreciate it and I am sure my other colleagues would. Thank you, Mr. Chairman.

Mr. ROYBAL. Sure. We'll ask Mr. Lynch to do that and any others that may wish to do that.

Mr. DAUB. Thank you, Mr. Chairman.

Mr. ROYBAL. Now, the reason for that is that we have a vote on the floor. We would like to cast that vote and then come back. It will take about 10 minutes. We are now in recess.

Mr. DAUB. Thank you, Mr. Chairman.

[Brief recess.]

Mr. ROYBAL. The committee will resume its hearing. I'd like to start my questioning with Reverend Garner and ask him to tell us more about the coalition.

Reverend GARNER. In any specific area, sir?

Mr. ROYBAL. If I can get to my notes, I will be more specific.

[Pause.]

Mr. ROYBAL. You made reference to the fact that the companies offered a buy-out, that there was an offer made that they would cover the individual for 6 years or receive a lump sum.

Reverend GARNER. I would need to clarify that. That's not specific enough.

Mr. ROYBAL. Would you please clarify that for us?

Reverend GARNER. Sure. Just recently they offered a buy-out. By the way, I doubt that "buy-out" would be their term, but we believe it is accurate.

They will offer each individual pensioner either a lump sum payment or a monthly payment which would remain at a fixed level, regardless of how health insurance goes up over the years. At the present time, this is in court. They first sought the judge's approval. As I understand, the union has until the end of August to submit a statement explaining why they think the individual retirees should not accept this buy-out, and then at that time the judge will review these, then put them together in one package and send them out.

There are 4,118 pensioners affected by this and, again, I have some survey results that we have taken that I could submit for the record.

Mr. ROYBAL. I would appreciate it if you would submit it for the record at this point, and to conclude my questioning, then yield to my colleague, Mrs. Schneider.

I would like to ask you whether or not I am correct in my assumption that the Colt Industries problem is merely one of a breach of contract, that should be settled in court?

Reverend GARNER. That, I am afraid, has been what many people have thought and I would like to stress that I and the coalition would disagree with that statement. On a contractual, litigational, level it is a manifold problem. I would not even hesitate to say that. But on a personal and moral level it is not. If all you had was this little, green booklet that I have shared and will be in the record, then yes, perhaps it would be contractual. But then you also have to add the fact that thousands of lives are being destroyed. You also have the element, very simply and basically, that the people sat down face to face, with high management people from Crucible, and were promised lifetime health benefits oftentimes with their spouses and dependents present. And so you have, certainly, the contractual issue, but you also have the personal and the social responsibility of corporations to live up to their promises to towns and to individuals.

So, we have been coming at it from the angle of the moral and the personal and the social responsibility that Colt has to each pensioner that they promised personally and individually.

Mr. ROYBAL. How do you propose that this matter be solved?

Reverend GARNER. The Colt issue in particuilar?

Mr. ROYBAL. The Colt issue in particular.

Reverend GARNER. Well, my ideal, I guess, would be that Colt relent at this point. That is, of course, ideal. One of the basic problems of this situation, as I understand it, is that the pensioners, do not have a bargaining unit. According to a Supreme Court ruling early in the seventies, in a United States Steel case, the union cannot represent pensioners because they are no longer dues-paying members, unless the company says that they may.

So, the employees really have no bargaining rights. They have no leverage whatsoever in which to fight this.

We appreciate the efforts the union has made and we encourage them to continue in negotiations.

We have been involved in this from a public relations standpoint because much of the bargaining power that the union had at one point has been taken out of their hands. They no longer have a mill, there is no longer the strike power that could be used, there are no longer many of the elements that they used to have or tools they used to have. And so, through public media, we have been bringing this before the people to get public opinion mobilized against them. That has been our basic tactic.

Mr. ROYBAL. Reverend Garner, I am going to yield to Ms. Schneider now, but I am going to ask you when we get back to you again, one question. What can Congress do about this situation?

Reverend GARNER. The Colt situation?

Mr. ROYBAL. Yes. And I'll give you the time to think about it and then you can answer that question when we get back.

Mrs. SCHNEIDER. That's too bad, Mr. Chairman. That was my question.

Mr. ROYBAL. All right. If that's the case, on Mrs. Schneider's time, will you proceed in any manner that you desire?

Mrs. SCHNEIDER. I regret that I was not able to be here during the presentation of your testimony. I was conducting hearings of my own. But I apologize if I ask you a question that you have already answered, but if you would bear with me I would certainly appreciate your response.

Mr. Gajda, the survey that you conducted, one of the things that jumped at me was the fact that 36 percent of the retirees pay virtually nothing toward their health care costs under various health plans. Give me a little bit of response to that and what you think ought to be done or what approach we ought to be taking.

I mean, obviously it's inequitable.

Mr. GAJDA. Here it is. Which one caught your attention?

Mrs. SCHNEIDER. The 36 percent of retirees pay nothing at all toward their health care costs under certain health plans.

Mr. GAJDA. Right. As you can see from the summary, the range on the employees' share of costs, 36 percent pay nothing for themselves. In fact, even 27 percent of the firms provide the spouse coverage at no cost at all.

It's impressive. It seems to appear that firms are really providing this wonderful world of benefits for their retirees at no cost. That may be the case. It's not necessarily the case.

We are talking about the cost of the benefits and we're not relating that or correlating that to the benefits themselves. While we know that a good many of these plans, from our summary, are reasonably good plans, it may be that some of those are the less good

plans or the less liberal plans, or the more restrictive plans that cost nothing.

But there is some tradition in this country in industries with the State and local government taking the lead where benefits are provided without cost and they are continued without cost into retirement. Another sector where we find that also is in the public utilities sector.

Mrs. SCHNEIDER. But aren't we now at a turning point in society where, perhaps, some of the ways of doing things 20 or 30 years ago were acceptable, but given our altered economic environment that that kind of formula no longer is appropriate for the future, especially considering the changing demographics and the increasing number of elderly?

Mr. GAJDA. Your question goes to one of our recommendations in our written remarks, where we suggest that benefit plans for retirees be designed to efficiently provide benefits. And by "efficiently" we mean that the retiree have some incentive to use health care efficiently, and that incentive can be created a number of ways. So, the way that is winning a lot of attention these days is to have the benefit plan pay something less than 100 percent of the cost of care, 90 percent or 80 percent, so that every time the active employee or the retiree visits a physician, there's some cost to him. It's a no cost or a free consumption item.

A second way of instilling that incentive to consume care efficiently is to have the employees contribute some share of the cost. And it can be nominal. But it's coming out of a pension check. So it will be seen every month. When they get that pension check they will see that it's coming out.

If you're asking are we past the time when as a Nation or as an economy we can afford to provide these benefits at no cost, if we're not, we're going to be approaching it. People are going to become much more sensitive to an item that, frankly, 3 years ago nobody would have noticed, that 36 percent of these benefits were free.

Mrs. SCHNEIDER. I think that if you were to talk to any man or woman in the street, I think that their attitude, philosophically, is antigiveaway programs. But yet many of them don't realize that they are beneficiaries of, essentially, programs where they are not contributing at all.

Mr. GAJDA. They would deny it even if you told them. Until you started questioning them and made them start thinking about some of the things that they have that really would fall into that class of programs. You're absolutely right.

Mrs. SCHNEIDER. Well, I see that as we are moving now in a whole broad spectrum of things, whether it be in cost-sharing programs for building merchant marine vessels or cost-sharing programs for environmental protection, it seems to me that we have a limited number of years remaining before we need to radically restructure the system of private pension plans. Do you not agree with that?

Mr. GAJDA. Well, yes. The cost sharing is something that, as I said earlier, we're doing just about every day with our clients.

The fact that benefits may be provided without any retiree share of the cost, doesn't force up utilization. It doesn't make the retiree sensitive to the utilization. And we have to—the difficult problem,

though, as I'm sure Mr. Lynch will point out, is that just as retirees who had medical benefits for all their retired lives, whether that would be 1 year or 5 years or 10 years or 20 years, and then loses them, you're also dealing with an emotional issue when you talk about forcing or requiring employees to pay some portion of the cost of their benefits. You're talking to people who may have truly had benefits at no cost since the 1940's, since we first started inventing fringe benefits. For 40 years they may not have paid a penny for their health insurance.

And you come along now and say, "This is in your interest." That's really what you're saying. "It's in your interest to control the costs so we'll never have to come back and cut these benefits, and it's in your interest because we're going to help you find better ways of getting care. It's in your interest to pay 10 percent or 20 percent or 50 percent or 99 percent of the cost of these plans." It's going to become very, very emotional.

And if you can solve the problem of terminating these retiree plans today, that issue will take its place.

Mrs. SCHNEIDER. Well, granted it's emotional. But it's going to be far more emotional and shocking if we don't send that message now and it would seem to me that that's the responsibility of the labor community and the business community and everybody, to alert the American public that "times are a'changin'" and we've got to change our structure of benefit programs.

Mr. Lynch, I know you're real anxious to say something. Would you like to comment?

Mr. LYNCH. Yes. I would like to comment. Of course times are changing. But I think you're right that we have to take a fresh look at what actually we're talking about. We're talking about a package where you have included a pension program which was part of a collective bargaining agreement. You're talking about something that was obviously a piece of a cost that was factored into the total cost of that package, and which was regarded as wages. And that, of course, is a cost that our members are not receiving on their checks but it's still a cost to them, in the total package.

And the concept is that we negotiate these benefits, including the pension benefits, as a total cost in that package. And we never negotiate leaving out the cost of pensions and insurance and other health care services. So those are regarded as costs that our members are paying but not handling, not money that our members are receiving and giving back, but yet it's something that's being paid by the company on behalf of employees and regarded as part of their wages.

Now, in instances where you have employers that have pension programs and believe that it's in their best interest to provide these benefits to employees and they're not unionized, we're happy to see that. But yet we don't know that those kinds of pension programs will have the kind of validity and teeth, and may be the kind that would be opting out, if, in fact, you'd go to some kind of a prepaid program. Because they may not mean much anyway. They may have intentions, if they get in a financial crunch, of not paying those benefits, as Colt is making an effort now. That's why we think it's so important to have some kind of guarantee that

once people have been committed to a lifetime pension benefit or insurance benefit, that that is there for them and if prepayment is a way to get to that, we're all for it. And I think that you may misconceive that we are going to willingly accept, now, our members' feeling that now, even though this package which included the pension programs and insurance programs that had been paid as a part of their wages previously, now they're going to have to double pay it. They're going to have to get their checks and pay additional money for those benefits. And we're opposed to that, where we collectively bargain those agreements.

Mrs. SCHNEIDER. Understood. Thank you.

Mr. Goldbeck, I would just like to briefly ask you what happens to the smaller businesses that are not unionized and that might have just 30 or 20 employees?

Mr. GOLDBECK. Well, every problem that pertains to personnel and its financing that you find in large businesses are magnified many times over in the small business circumstance. The most glaring example is that some 40-plus percent, closer to 45 percent, of small businesses today in America don't provide health insurance for their active workers. The prefunding retirement benefits is far from their minds at this point. So, there are huge gaps in there and I think the question that Congressman Daub was so impassioned about as to whether companies were going to drop their benefits is one that would be much more germane to most of the smaller companies than it would be to the U.S. Steel's or AT&T's or Sear's or companies of that ilk. There really is a very different set of circumstances there and I think the Congress would have every reason to look very carefully at where you would make cutoff points if you do move forward on any of these kinds of endeavors that would require new reporting and new mandates on employers.

The small businesses have a very different set of circumstances.

Mrs. SCHNEIDER. But you do see some solutions or recommendations for small businesses?

Mr. GOLDBECK. Well, there is no question that there is a great deal that small businesses can do to reduce the waste in the medical care benefits themselves, right now. Small businesses must group together so they have the same economic purchasing power as larger employers. There really is no other way to have good benefits and not be overcharged. There is a lot that can be done, quite apart from addressing guarantees for retirees, to stop the waste that we have in medical care costs today in this country, which is absolutely egregious.

I mean, if you look at any major employer in this Nation today, they can cut 20 plus, some feel very comfortable saying 30-plus percent of their medical expenditures and improve the quality of the benefits, by making it a well designed benefit and taking from the medical care industry the information that enables you to find efficient medical care providers.

Now, that last step is precious difficult because, as you can well imagine, there is no great rush on the part of doctors and hospitals to be coming forward with lists that provide you with their comparative prices or their comparative quality indicators. So, it's darned hard to find out where that efficiency and excellence merge.

But, we have good examples of it so we know we're not shooting in the dark. I provided in my written remarks just a couple of pages of items to demonstrate how dramatically a single company, through even one program, much less a coordinated, integrated program, can save hundreds of thousands of dollars very quickly. Now, those savings are just sitting there waiting for other companies, large and small.

Now, on the other hand, what happens when those, when a private firm does that, and then the next week the Congress decides that they're going to find $11 billion in savings in medicare? That wipes out years of cost savings for the active workers. These are not problems that are necessarily separate, public and private, or public against private. We really need a much more concerted, unified, effort at cost management to get at the underbelly of the rising problem.

Mrs. SCHNEIDER. Is your organization strictly Washington businesses or are you a national organization?

Mr. GOLDBECK. In fact, it is not Washington businesses. I won't bore you with the history of how we came to that name, but we are an organization for national employers that have an interest in health policy and cost management issues.

Mrs. SCHNEIDER. You are a mechanism to get appropriate information out all across the country?

Mr. GOLDBECK. Yes, we are.

Mrs. SCHNEIDER. You have chapters in other parts of the United States?

Mr. GOLDBECK. We don't have chapters in the sense of a formal affiliation. What we have done is we have spent a lot of energy in the last 5 years starting State and local, "business groups on health" or coalitions. We have been directly responsible for in the neighborhood of 40 of those. But there is also now another 100-plus that have started because this has now become a movement. So you have everything from the Pittsburgh Business Group on Health to 19 coalitions in North Carolina——

Mrs. SCHNEIDER. I want to know about the one in Rhode Island.

Mr. GOLDBECK. Rhode Island. Well, Rhode Island has a different set of circumstances because as you know with the maxicap program in Rhode Island, you have the interesting phenomena where last year, the Blues, the hospitals, and the State negotiated a cap so that the maximum rate increase in the State of Rhode Island would be 7.8 percent. Governor Galarrity announced this with great fanfare, which was nice, except for the fact that neither management nor labor had any part in the negotiations. For some reason, there is still the mythology that the blues ought to have something to say about our money with none of the rest of us having a vote.

It is nice to have 7.8 percent, but it's interesting that 7.8 percent is in the year in which we have 3.4 percent being the rate of inflation. So we're inculcating a double rate even in one of the best controlled States in the Nation. So there are going to be problems even in Rhode Island.

Mrs. SCHNEIDER. Well, I would think so. I would look forward to discussing this further with you sometime.

Mr. GOLDBECK. It would be fun.

Mrs. SCHNEIDER. And Mr. Lynch, we are going to have a very long discussion tomorrow because I happen to be the chairman of the Republican National Labor Platform Committee.

Mr. LYNCH. I recognized your name.

Mrs. SCHNEIDER. I said, "I'm going to see that man tomorrow morning. I would appreciate it if you would include in your testimony tomorrow some of your comments that you made today dealing with health concerns and health care costs because I think that the testimony should be that broad and not just relate to labor issues.

I thank you for your indulgence, Mr. Chairman, and the panelists for their input. I'll be sure to be very studious and read all of this testimony.

Mr. ROYBAL. Thank you very much.

There is no doubt that the reason that we're here is because we know that employers are beginning to back away from their promises to provide health care benefits for their retirees. At least that is the allegation. The truth of the matter is that we see definite proof of the fact that this has taken place. Mr. Anderson has testified to the fact that he is practically wiped out. Ms. Nickelson has told us about her grandfather in almost the same situation.

Now, down the line, we find that what we've been told is something that is occurring. But what I want to know is why. Why do these companies do this? Now, I know that there's unemployment, a company terminates its existence, but, on the other hand, we were told by both Mr. Fuerst and Mr. Gajda that perhaps it's a matter of prefunding.

When I asked the question directly, Mr. Gajda gave me a yes and no answer. He said, "Yes, but not now," when it came to prefunding. Then I think he also said, "No, but later." Now there must be some reason for this and let us assume that we know what the reason is. But let us zero in on the financial reason for it, that is the matter of prefunding. Is prefunding something that should be recommended or be enforced in future plans? I ask that of both Mr. Fuerst and Mr. Gajda.

Mr. Fuerst, may I have your answer first?

Mr. FUERST. Yes, thank you. I believe that funding of these plans is extremely important. First of all, there are no funding requirements now. The promises that employers have made in the past and that, in some cases, appear to be broken now, I think that's primarily a matter for the courts to decide under the existing laws and the contracts that existed. We'll have to see how that's determined.

With respect to the future we must deal with the problem of the promise that's broken by the company that can't fulfill the promise. Some companies will go bankrupt and will be unable to fulfill it regardless of what the court rules. So I think we have to prepare for that. We have not in the past. I think that is an oversight and I think it's deplorable. I think there are many people to blame—both business and labor for not recognizing the costs, the consulting profession and the insurance companies for not making the vehicles available, the Congress for not building the tax incentives to actually fund these plans. The incentives exist for pension benefits, but they do not exist for medical benefits.

I think what has to be done in the future to avoid is, first of all, additional restrictions on the existing funding methods. We have some vehicles now yet in the past few months Congress has considered limiting them. Certainly, we can't have any further limitations. We have to expand the ways the companies can fund these plans and we have to encourage that funding through expanded use of vehicles like a 501(c)(9) trust or other trusts similar to pension trusts.

Allow companies to build up these reserves and allow them to deduct the contributions to those and shelter the investment income that those moneys——

Mr. ROYBAL. Is that the practice now, that they do, in fact shelter the contributions you make?

Mr. FUERST. It is, but only to a limited extent and the practice is not strongly encouraged so that very few companies have in practice done that.

Mr. ROYBAL. To what extent do you recommend that this be done then if it's done to a limited extent now?

Mr. FUERST. I would recommend that it be allowed on a basis similar to pension plans, that employers be able to expense these benefits over the working lifetime of employees and that they be allowed to make contributions to irrevocable trusts that would be designed to provide only benefits to retirees.

Mr. ROYBAL. That there be a tax benefit from those contributions.

Mr. FUERST. Yes, companies are not going to fund these plans without tax benefits.

Mr. ROYBAL. Is that being done now?

Mr. FUERST. Only to a limited extent. Not sufficiently to make the promise.

Mr. ROYBAL. Well, I would like to find out what that limited extent is. I don't understand that.

Mr. FUERST. In pension plans—if it's in a qualified pension plan, then the benefit has to be considered a minor benefit or an insignificant benefit in relation to the basic pension plan. With respect to 501(c)(9) trusts, the limits are not clear—there's nothing clear in the Tax Code or in the regulations as to the extent of the reserves that can be built up.

Most employers have interpreted the regulations to mean that they can only build up small reserves, enough to pay 1 or 2 years worth of benefits and that's not enough to make these promises to retirees. The legislation that has been pending in recent weeks in Congress would cut that back even further. The degree to which these benefits can be funded is much smaller than the degree to which pension benefits can be funded.

Mr. ROYBAL. Now you stated in your testimony that firms should prefund the cost of retiree medical benefits so that ample funds are available as employees retire and begin to claim benefits. But the cost of those benefits can be converted to a relatively constant annual cost so that the true cost of employment will be known. Tell me something about the conversion to the relatively constant annual cost.

Mr. FUERST. There are actuarial cost methods or actuarial funding methods which an actuary can use to estimate the amount of

money that's required to provide a benefit to an individual at retirement. He then can allocate or develop a cost method which allocates that cost over the working career of an employee so that if, for instance—in the case that I presented, the employer in that situation had contributed 2½ percent of payroll into a trust every year for all of the employees, when those employees retired there would be sufficient funds accumulated to provide the medical benefits that they were promised.

Mr. ROYBAL. Let's stipulate to the fact that that is what will happen in reality. But the question I am trying to get at is the tax benefits that the employer would be receiving as he sets up that constant annual cost. Does he get a full benefit from it? In other words, in the period of a year, he makes a contribution of $2,500 to that individual's plan. Does he write off those $2,500?

Mr. FUERST. As a deductible business expense. That would be what I would recommend.

Mr. ROYBAL. So he does in fact get a tax benefit at the moment?

Mr. FUERST. Oh, I'm sorry. I thought you were asking what I would propose would be done. No.

Mr. ROYBAL. I want to know the difference between the situation now and your proposal.

Mr. FUERST. The situation now limits the total amount of money that can accumulate in that trust. He might be able to make that contribution of 2½ percent of payroll for 1 or 2 years. But as the funds accumulated in the trust, there would be a limit of how large that trust could get with respect to benefits being paid out over the next 1 to 2 years. Future contributions would not be deductible and the investment income in that trust might be taxed.

Mr. ROYBAL. All right. Let me understand what you're saying. If that fund reaches a certain limit—and I wouldn't know what that limit is—but once it does, any further contribution would not be tax deductible. Is that correct?

Mr. FUERST. That's correct.

Mr. ROYBAL. Now that is the situation at the present?

Mr. FUERST. Yes.

Mr. ROYBAL. Now give us your recommendation. I don't want to do it for you.

Mr. FUERST. My recommendation would be that the full contribution required to provide for the benefits on a level funding basis under an acceptable actuarial cost method, that that full amount should be deductible.

Mr. ROYBAL. All right. So your recommendation is that through the congressional process, we make that available?

Mr. FUERST. Yes.

Mr. ROYBAL. What else do you recommend that Congress do, particularly with regard to prefunding and the problems we're talking about at the moment?

Mr. FUERST. Well, I think that the prefunding would be much attractive if the encouragements that exist for pension——

Mr. ROYBAL. Mr. Fuerst, would you excuse me?

Mr. FUERST. Yes.

Mr. ROYBAL. Ms. Nickelson, I would like to thank you for your testimony. I know you have to leave. We thank you very much. We

will submit some questions to you. I would like to have you respond in writing.

Mr. ROYBAL. Reverend Garner, I understand you have to leave pretty soon, too.

Reverend GARNER. No, I was trying to signal that I would be willing to answer the question you asked me originally.

Mr. ROYBAL. I'm ready for that. I'm saving you, Reverend. Thank you, Ms. Nickelson.

Ms. NICKELSON. Thank you.

Mr. ROYBAL. Will you proceed, Mr. Fuerst?

Mr. FUERST. Yes; I think that Congress should encourage the companies to fund these plans through the deductibility of contributions. I think that we should try to encourage a situation similar to what happened in pension funding many years ago in that companies began to recognize these expenses on their balance sheet or in their income statements and deducted these expenses.

So while merely allowing deductibility would be a step in the right direction, it's insufficient in that companies would not necessarily have to record an expense. Now this is an area that I think the private sector should deal with and, in fact, the Financial Accounting Standards Board is addressing this issue right now. I expect that they will be requiring much more disclosure about these benefits. These plans should be disclosed to shareholders so that the true expense is known and I think that a reasonable method of expense recognition in the private sector on the income statement of companies should be required.

Mr. ROYBAL. Now, Mr. Lynch, we know now that the employer does get a tax benefit from contributions that he makes up to a certain level. We also know that there's a recommendation that Congress do something about expanding that. What about the employee who also makes a contribution matched by the employer? What happens today? That employee, does he receive a tax benefit from that contribution?

Mr. LYNCH. I don't believe so; no. In most of our major contracts, they are noncontributory. We negotiate them on the basis of getting a certain benefit level and those benefit levels are costed out and that's treated as a part of the wages of the employee but it's actually paid by the employer in most of our contracts.

Where we do have in some small contracts a contributory kind of arrangement where our members pay a part, I don't believe there is any provision for them to get any benefit—tax benefit—as a result of those contributions. But I could be wrong. I will check that out.

Mr. ROYBAL. I don't think that you are, but I would appreciate if you would confirm your statement.

Mr. LYNCH. But I would like to say further, based on the statements that were made with reference to tax benefits being given, I think it's almost imperative, if you are going to go to prepaid funding, it seems to me that they ought to guarantee that those benefits will be paid in the agreements.

We were, unfortunately, misled by a number of employers when we negotiated. We had in the collective bargaining agreement and also in the pension programs and insurance programs certain bene-

fit levels that we agreed to and we trusted that these employers would get whatever kind of insurance that they needed in order to be able to pay those benefit levels. Now, obviously, that is not being met in some instances and that's why I think it's important that the Congress get involved in it.

Mr. ROYBAL. Well, don't you think that if we were to follow the plan of prefunding that we would also have to do something else? We have to look at cost containment and that one without the other wouldn't work. Is that a correct statement, Mr. Lynch?

Mr. LYNCH. I think it's absolutely correct. Unfortunately, that's one of the things that has been runaway for a long time and my organization has, in fact, been in favor of national health insurance, where everybody would be guaranteed a quality health care service and have the Federal Government pick up the whole tab or have some insurance paid by each of the individuals that receive it, based on their ability to pay. But everybody should be entitled to insurance.

Yet I believe that the question that you asked, you answered it properly.

Mr. ROYBAL. Mr. Goldbeck, what do you think of that, particularly the last statement that was made by Mr. Lynch?

Mr. GOLDBECK. Well, we have never been totally enamoured of the idea of having a single national plan. What's happened in the last few years probably gives more credence to the advantages of not having a single plan than any rhetoric we could have originally come up with. Today, the most innovative and progressive plans to manage cost have emerged in a variety of States, not one of which parallels any of the proposals for a single national plan.

The DRG program itself, that Congress enacted last year, was a result of one State experimental plan that was extrapolated and modified and so forth, and had you not had the opportunity to have that sort of—waivers being the current term—we would not be receiving the benefits of that program today.

Even though we may approach it somewhat differently, I certainly agree with Mr. Lynch on the severity of the problem and the fact that it is something that requires the public and private sectors working together, albeit that does not necessarily imply total national uniformity.

Mr. ROYBAL. Well, you do agree then that we should institute cost containment efforts?

Mr. GOLDBECK. Oh, without question.

Mr. ROYBAL. Do you think that business would support legislation to control costs?

Mr. GOLDBECK. Well, that depends on what the legislation is. Business did not—and I will freely aline myself with that—we did not support the Carter caps because we felt it was a poorly designed program, not because we didn't feel that costs were a legitimate problem.

At the same time, we went ahead and supported governmental involvement, for instance, in the PSRO program and some of the planning programs and we are now supporting the fact that it is high time for the Federal Government to become involved in correcting the malpractice problems. But I don't wish to in any way imply a bias that says that if the Government is doing it, it's neces-

sarily bad at all—not at all. But there has not yet come before our eyes a single Federal proposal that would resolve the cost prcblems with the stroke of a congressional pen.

Mr. ROYBAL. Well, that is true. Not one single piece of legislation is going to do anything. A perfect piece of legislation has never been drafted——

Mr. GOLDBECK. Certainly not in this area.

Mr. ROYBAL [continuing]. And that it will any time in the near future. But we have to approach this matter of cost containment and we have to use the expertise of individuals like yourself to bring to the Congress different ideas and perhaps try one and if that doesn't work, we try something else.

But I would like to have from Mr. Goldbeck and also Mr. Lynch in writing what your recommendations would be to the Congress with regard to cost containment legislation. It doesn't have to be long. It can be short.

Mr. GOLDBECK. That's a small problem.

Mr. ROYBAL. We'll come to back to you in a moment.

Mr. GOLDBECK. Thank you.

Mr. ROYBAL. Reverend Garner, I asked you a question just before we heard from the other witnesses. Would you like to answer that question now.

Reverend GARNER. Thank you. I appreciate the time to think.

I think first of all I need to clarify something. We've really been talking about two different situations today. The first situation is the one Sandra and August and I are involved in, that is companies which have found themselves in this plight and have chosen to renege on their commitment, whether it was verbal or written or both.

The second situation envolves companies that are going to be facing such a dilemma in the future, whether that's a near or far future. We seem to have been talking about both without distinction. But they are distinct in a very real sense of the word. One needs curative and the other preventative measures. But what can Congress do.

First of all, preliminarily, we're of the firm opinion that a change is necessary in tax laws which make it profitible for companies like Colt and Bessemer, or whoever they might be, to close down. Originally, Colt was intending to sell the mill. After Universal Cyclops offered them up to $100 million to buy the mill, including all of the pension costs, benefits costs and so forth, Colt turned them down and took a $193 million tax writeoff—which is included in Appendix 3 of my written testimony—and sold the mill to J&L for $8 million.

It encouraged them—the current tax laws—to go ahead and shut down. These are the type of things which have precipated many of the problems. That's a preliminary measure. So reviewing and perhaps changing the tax laws that precipitate matters such as this is one solution.

Second, Congress can enforce promises made by companies and make sure that they are fulfilled. There's really no one but the Federal courts right now to ensure that they are being fulfilled, and that is a lengthy, costly and time consuming process. Congress can watch out to make sure that these promises are fulfilled.

A third way is to clarify ERISA and that would entail spelling out that ERISA forbids a company from terminating retiree benefits unless a right to terminate is clearly disclosed in the summary plan description—and that would be in the benefits booklet I am submitting for the record. They could forbid termination unless the plan or agreement makes clear that the company has a right to terminate. Basically, what I mean is that unless companies have specifically included a section about the loss of employee benefits with regard to shutdown in their summary plan, they should not be allowed after the fact to add such a clause or interpret it in such a way that allows them to terminate. So it's matter of interpretation and clarifying ERISA.

Fourth, I would encourage Congress to ensure that during an anticipated insurance blackout the pensioners would still be covered by some sort of health insurance. Some of the problems that have encouraged Colt's highhanded measures and strong-arm tactics stem from the fact that they know this blackout would be so economically devastating to these people that the union has to negotiate for much lower than they ordinarily would if this were not hanging over their head. I think right now negotiations are very lopsided and need to be on fairer terms. I think Congress should work on somehow shorting or covering these people during that time.

Fifth is cooperation—and this is something that our coalition really is dedicated to. I have used the term "forcing cooperation" at times and I realize that that's acutally a contradiction in terms, but somehow giving incentives for corporations and employees to cooperate or to work together to cut down the costs of their medical insurance without throwing the burden on the employees and especially the retirees. There has been no cooperation so far, only highhanded measures.

I was reading a letter that Sandra's grandfather received, from the corporation that she is testifying about and basically the corporation said, "It is going to terminate. We just wanted you to know a month in advance," and that was their only notice. It was just put in front of them.

So somehow giving the incentives that would encourage companies, employers and pensioners to cooperate—one such relating to Medicare would be a more comprehensive effort by Congress to cut costs rather than simply shift the burden to private insurance carriers, which is happening now in much of the legislation that's been passed regarding medicare.

Those are some that I could put together in the few minutes I had.

Mr. ROYBAL. I thank you very much. I think you did quite well.

I would like to ask Mr. Anderson a question and this is based on the fact that I agree with the assumption that has been made that there is an implied contract between the employer and the employee at the time that that employee goes to work and that implied contract is with regard to your medical plan.

I would like to know more specifically, at the time that you were hired, were you under the impression or were you told that you would have a benefit—health benefit—for the rest of your life?

Mr. ANDERSON. I was not told when I retired because I retired after the plant closed, but retirees prior to plant closing were told that they had hospitalization for life.

Mr. ROYBAL. Well, so it was your assumption that it was the policy of the company that they would have benefits for life?

Mr. ANDERSON. Yes, hospitalization for life.

Mr. ROYBAL. Now when your plan was terminated, how much notice did you get?

Mr. ANDERSON. How much what?

Mr. ROYBAL. Notice.

Mr. ANDERSON. I think it was 30 days.

Mr. ROYBAL. Which is the same as Ms. Nickelson.

Mr. ANDERSON. Yes.

Mr. ROYBAL. The 30-day period. And at that time——

Mr. ANDERSON [continuing]. Everything was stopped.

Mr. ROYBAL. Was it by letter?

Mr. ANDERSON. Yes, I think I have the letter here.

Mr. ROYBAL. You do have the letter—oh, counsel tells me that we already have it here—because I was going to ask you to make it part of the record if it were possible. We will include that in the record. Can I have the date of that letter? Do you remember the date, Mr. Anderson?

Mr. ANDERSON. That I was terminated?

Mr. ROYBAL. Yes, sir.

Mr. ANDERSON. It was October 29, 1982.

Mr. ROYBAL. That is a date, no doubt that you will never forget.

Mr. ANDERSON. Right.

Mr. ROYBAL. Thank you very much, Mr. Anderson.

I have something else I would like to go into just briefly. It was touched upon a little while ago and this was with regard to a national health plan that Mr. Lynch made reference to.

I asked Mr. Goldbeck what he thought and he gave me his opinion. Now, Mr. Fuerst, you're an actuary and Mr. Gajda is an economist. Can you tell me your opinion with regard to a national health plan?

Mr. FUERST. I would be quite skeptical of the effectiveness of a national health plan. I think that plans—benefit plans—such as this are best provided through the private sector. I think that that's been very well demonstrated with the pension plans that exist for most employers. I think that medical plans are similar and would best be provided through the private sector. I think that providing one plan for all the citizens in our country would be quite inflationary in the medical industry. I think that we have seen quite a bit of inflation in the medical field since the passage of medicare. While it's been beneficial legislation, it's also had some negative aspects to it.

Mr. ROYBAL. Is that your political opinion or is that actually based on sound, actuarial principles? Now, what I want to know is can such a plan be actuarially feasible?

Mr. FUERST. I think that the comment that there has been inflation in medical expenses since medicare was passed is a fact. I think that can be demonstrated. That there is a causality there is not an actuarial fact that I can demonstrate.

39-353 O - 85 - 7

Mr. ROYBAL. Well, isn't it also true that there are other factors that have added to inflation——

Mr. FUERST. Yes.

Mr. ROYBAL [continuing]. And this was not the sole factor?

Mr. FUERST. Exactly right. There can be other factors. Is it possible to provide national health on an actuarially sound basis, is that the question?

Mr. ROYBAL. Yes, sir.

Mr. FUERST. I think that it's possible. I am not sure that I could tell you exactly how it would be done at this point, but it's possible that that could be done. Personally, I don't believe that it would be beneficial, but I believe it's possible.

Mr. ROYBAL. All right. What I am asking is, "Is it possible," and you stated, "Yes, it is possible." Now what do you think, Mr. Gajda?

Mr. GAJDA. If your question to me is, "Is it possible," the answer is, "Yes," but I would love to spend a minute or two on that.

Mr. ROYBAL. Well, as an economist, you tell me what the implication would be with regard to the economy of the Nation and then compare with expenditures made for military spending for an example?

Mr. GAJDA. I'd be delighted.

Mr. ROYBAL. If it's done with comparisons, perhaps I can understand. I am not an economist, I'm just an accountant.

Mr. GAJDA. I happen to have recently done a paper on health care cost dynamics and the beginning point of that paper was a link or a correlation between health care enfranchisement of 18 million elderly in 1965 and several million more who qualified for medicaid in 1965.

These were people who virtually had little or no insurance before titles 18 and 19 were signed. After medicare and medicaid came into being, we can show very clearly what it did to the health care system in this country. The number of hospital beds in this country increased by 55 percent between 1960 and 1980, for a very good reason. You have got some people who can now seek health care and you've got to have beds to put them in.

The number of physicians increased by 75 percent between 1960 and 1980 because, again, these people have to be cared for, the insurance is available. We have built a huge health care system in this country. It's become vastly more complicated. It takes about three-fourths more people to care for the same number of people in hospitals—hospital workers. It takes about three quarters more, 75 percent more, to provide a day of care today than it did in 1960. Now if we talk about national health insurance what we are saying is that for a large sector of the population, and frankly, I don't know what it is, because it's going to be tens of millions of people, we're going to give them some health insurance that they have never had or don't have or we're going to have some improvement in the health insurance that they do have and we're going to have a second plateau in this increase in the size of the health care system.

If we take a look at the kind of inflation and the growth of the health care system, I think that's what's key. We're spending close to 11 percent of gross national product on health care. It means we

can't spend that 11 percent on something else. That something else might be anything. It could be food. It could be education. It could be anything else we can spend that money on.

With national health insurance, what we would be doing is taking the design of health insurance out of the hands of the people who receive it and who pay for it—employers and employees—and we have a whole wide range of health insurance plans in this country—we think and we believe because they suit the objectives of those firms and those employees. But we would be saying that we're going to supersede that judgment and put in some national health insurance and that is, I think, one of the disadvantages because then we're going to have instead of varying health insurance costs that reflect what the employees want and reflect the price structures of particular industries, we are going to have a uniform health insurance cost across all firms and across all employees.

It can be done and it can be actuarially sound. Actuarially sound—all that means is that you're going to pay the price the actuaries come up with. If that price is 20 percent of GNP, if you pay the 20 percent, it's an actuarially sound system. But there are going to be other parts of the whole economy that are going to have to give up 9 percent to put that up to 20 percent in the health insurance.

Trying to relate this to defense industries is at once easy and difficult. The defense industries—those that are truly defense industries that do nothing but produce defense equipment—are probably the purest form of monopoly and the only thing that saves us from vicious, monopolistic pricing is the fact that we do have a number of those defense contractors out there. I don't know. I am not familiar with defense other than it's out there, it's a big industry, the biggest piece of the Federal budget. But the fact that there are a number of them does create some competition and is going to have some dampening effect on costs of defense while national health insurance, if it's designed in the way national health insurance is designed in most of the industralized countries that have it, would not give you that kind of competition that you might have in the defense industry unless you created that competition in your national health insurance.

Now, the fact that national health insurance operates in vastly different fashions and at vastly ranging different costs throughout the world suggests that there is not one national health insurance program out there. There are a whole variety. You can structure it in a variety of different ways and you might be able to embody some competition into a national health insurance plan, but that's going to require a great deal of work and a great deal of resources and a great deal of effort and it may simply not be done because it does require that kind of commitment.

Mr. ROYBAL. Don't you think that there is only one of two ways to go? One is provide this national health program or a combination of both, but as Mr. Goldbeck, I think, stated, business and industry, together with the Congress and everyone else could come up with a specific plan. I don't see which way we are going at the moment. Do you, Mr. Gajda?

Mr. GAJDA. No, I don't, and I would be surprised if anyone in this room knows and I would be surprised if anybody in the health care sector knows where this industry is going.

Mr. ROYBAL. But we do know that the cost is increasing every day.

Mr. GAJDA. Yes, we do.

Mr. ROYBAL. We do know that insofar as medicare is concerned, the senior citizen is paying more now than he did even before he had medicare. Those things we know.

Mr. GAJDA. Those are all realities.

Mr. ROYBAL. Why can't a Nation that can send people to the Moon not come up with an answer to something that seems to be so simple? And as an economist and as an actuary, maybe you can give me those answers.

Mr. GAJDA. You can probably get somebody to the Moon because you can put somebody in charge of getting somebody to the Moon who brings together the resources.

Mr. ROYBAL. But what about the tremendous cost?

Mr. GAJDA. I don't know that cost was a consideration in getting somebody to the Moon.

Mr. ROYBAL. That is the problem right there. I think you hit the nail on the head. Cost has not been the consideration.

Mr. GAJDA. But it was a discreet cost. It was what we might call a project cost, an enormous cost, but not coming up every year.

Mr. ROYBAL. Well, we don't know that it was a discreet cost because it was a one-trial balloon. It cost a lot of money, we know, but it was still cost and that's what we're talking about. What do you think, Mr. Lynch?

Mr. LYNCH. Mr. Chairman, I certainly agree with what I believe your sentiments are. It seems to me that we have to find ways of taking care of people in this country that are sick and can't pay for taking care of themselves. In situations where we have work relationships we thought we were doing that in our collective bargaining relationships. But unfortunately, some of these employers are reneging even on those commitments that they have made by written contract or written agreement.

So I think that the Congress has a responsibility to see to it that every citizen of this country has the opportunity to remain healthy and has the opportunity to live in a fairly decent condition once they grow old. That means that they have a responsibility of finding ways of ensuring and guaranteeing that these citizens have those benefits.

Now, I don't have a blueprint that could provide those kinds of securities, but I think we have enough smart people in this country. I haven't seen many insurance companies go bankrupt, but I have seen a lot of other companies around this country—some 25,000 within the last year—go bankrupt and I recognize that obviously the insurance companies are making a pretty good amount of profit.

I haven't seen many health facilities go bankrupt unless they were private and weren't able to get enough money that lived in those communities where they have had plants and other facilities go bankrupt or go down and not have any money to pay for those benefits that they have in those various health facilities. But it's a

problem that we have to bite the bullet on. You know, we can't sit idly by and be in responsible positions and allow people to be sick in this country without care or to grow old without adequate financial security. That is, I think, what the Congress really has to address itself to and I would hope that—and I appreciate your giving us this opportunity to be here to say what we have to say about this and certainly hope that you will be able to convince a number of your colleagues to do what's right in this important area.

Mr. ROYBAL. Thank you, Mr. Lynch. I should give the last word to Mr. Goldbeck.

Mr. GOLDBECK. I appreciate the opportunity.

I certainly agree with the sentiment just expressed that we have a growing problem of access to care in this Nation simultaneously with improvements in the access for a lot of people and in the quality for a lot of people. We do not have a uniform problem. Therefore, it's suggested that we probably will not have a uniform solution either. We have more people today that are without care—some 20-plus million people—not counting those that may be losing it through the problem we have been addressing here today.

On the other hand, we have more people today with higher levels of health insurance than at any other time in the Nation's history. So you're seeing a balancing issue here.

It is very important to recognize that the nations that have national health insurance are without exception developing private systems because the national system cannot hold up under the economic pressure. Every one of them is doing it a different way. Again, it suggests that nobody has been able to find a uniform, singular approach that truly is effective over time, and I would caution that we don't try and find one single approach.

The closest this country has ever come to having the Federal Government so-call design a system was for what ought to have been a very manageable piece of the population, the elderly in the midsixties. And if that's a model of the success of a governmental program effort, we're all going to be in deep trouble if we try and apply that same approach to the entire population.

We need to find a balance between competition and regulation. We have been trying to develop an objective of an efficient medical care marketplace, bounded by responsible regulation to help ensure access for those in need and improve quality where there is inappropriate behavior on the part of providers. That can be achieved. The DRG system is a step in the right direction. A number of the programs that the private sector is doing today with incentives are also steps in the right direction.

We have to create a much greater balance between prevention and medical or curative care. We do not or will not have the funds to simply rely on after-the-fact care. That does not mean that we deny people who currently have medical problems the means for treatment. But it does mean that we know today, unlike four decades ago, how to preclude a lot of the demand side. We currently expend between 1 and 2 percent of our Federal dollars that go to medicine on prevention. That's a balance we can't retain if we want to continue to make affordable progress.

My final point would be that we are also learning a lot more about how to negotiate for medical care and how to use different

kinds of delivery systems. Much of this discussion has focused on the classic insurance model. You buy an insurance policy and you hope the employee ends up getting care in the right place. That is a very false hope—all too often. Most people have never had freedom of choice in this Nation. They have had the freedom to choose out of ignorance. That's a very blind freedom.

May I offer one suggestion? That the Congress go about the process of guaranteeing unions and management and State and local governments and thus through them the consumer access to comparative provider specific information so that we can become informed consumers, so that we can go to centers of medical excellence which are efficient. That, by itself, is also not a singular solution, but I will guarantee you unless we have an effective market, the governmental programs will never work by themselves.

Mr. ROYBAL. Well, Mr. Goldbeck, may I thank you and Messrs. Lynch, Fuerst, Gajda, Reverend Garner, and Mr. Anderson for your testimony this afternoon. We have another roll call, but instead of resuming the hearing, let us now adjourn and if you have any suggestions that you would like to submit to this committee in writing, we would greatly appreciate it.

We wish to thank you for your testimony.

The hearing stands adjourned.

[Whereupon, at 4:06 p.m., on June 27, 1984, the hearing was adjourned.]

APPENDIX 1

CORPORATE RETIREE HEALTH BENEFITS: HERE TODAY, GONE TOMORROW?

A Briefing Paper for a Hearing of the
House Select Committee on Aging

June 27, 1984

INTRODUCTION

In the face of double digit health care inflation the health benefits promised to retirees by America's employers are in serious jeopardy. Thousands of retirees have already lost their benefits and many others have been faced with major benefit reductions. The problem is only now beginning to surface and unless something is done to bring it under control, it will reach crisis proportions in a few years.

Until recently, retiree health care costs have been a major, though often overlooked, component of an employers' health care bill. With few exceptions, employers provide full health care benefits for retirees under age 65 and eight out of ten large employers offer supplemental Medicare coverage for their post-65 retirees. The average costs for retiree health coverage range from $2,000 to $5,000 per year for each retiree under age 65 and $600 to $1500 for those 65 and over.

The liability for retiree health care costs are staggering, especially among industrial employers. As the number of retirees rises, the total cost of providing health benefits rises accordingly. In the older "smokestack" industries for example, it is not uncommon for employers to have twice as many retirees as employees. Some experts estimate that for the Fortune 500 companies the liability for health care benefits is $2 trillion, while the total assets for these companies is only $1.3 trillion. Moreover, these costs are rising at a faster rate than for employees. A major eastern steel manufacturer reports that retiree health costs as a proportion of total company health costs rose from 3% in 1975 to 31% in 1983.

In response to these skyrocketing costs employers are reconsidering the promises they have made to their retirees regarding health benefits. In some cases, the benefits have been cutback. In others, the contributions by retirees for premium payments, deductibles and copayments have been increased substantially. These benefit modifications may not be too serious for active employees who still have a steady and increasing source of income out of which they can pay these additional costs. But, for retirees, whose incomes are not increasing and who are unable to supplement their income from work, the increased costs can be devastating.

The most devastating problems for retirees occur when the benefits are cut off altogether. This often occurs when a plant is closed or the employer faces major financial difficulties. When employer-sponsored health benefits are curtailed, retirees face two choices: buy insurance on their own at exhorbitant cost, or do without. If the retiree is too young to be eligible for Medicare, doing without insurance can spell disaster. Even for those covered by Medicare the problems can be severe.

THE FACTS

There are no precise national figures on the number of retirees who have lost health benefits nor on the value of those benefits. Below is a summary of available facts on retiree health coverage.

How Many Retirees Are Covered by Employer Plans

Nationally, more than **5.5 million** middle-aged and elderly retirees are receiving all or part of their health benefits from their former employer or from their union. In addition, more than **3.8 million** spouses (nearly all of whom are women) are receiving employer- or union-sponsored health coverage.

Most of the retirees who are covered by an employer- or union-sponsored plan are age 65 or over (3.7 million), but few such plans cover spouses over age 65 (240,000). Nonetheless, one out of every six elderly Americans is receiving a portion of their health coverage from an employer or union. And, two-thirds of the beneficiaries of employer sponsored retiree health care coverage are receiving benefits in addition to Medicare.

EMPLOYER OR UNION HEALTH BENEFITS
COVERAGE FOR RETIREES

AGE	RETIRED (000's)	SPOUSE (000's)
45 and over	5,537	3,816
45-64	1,810	3,602
65 and over	3,727	204

Source: National Medical Care Utilization and Expenditure Survey, 1980. Unpublished data prepared by the National Center for Health Statistics.

How Many Employers Provide Coverage for Retirees?

Most large employers and many smaller employers provide coverage for early retirees, i.e. those who retire before age 65. And, most large employers provide coverage for retirees past age 65.

- o A 1983 Hewitt survey of 710 major U.S. employers found that 88% provide post age 65 health benefit coverage: 52% offer a carve-out plan; 27% offer a supplemental plan and 7% offer coordination of benefits with Medicare.

- o Post age 65 coverage has become more common in recent years, according to a series of Hewitt surveys of 250 major employers conducted between 1979 and 1983.

- o A Chicago area survey of 200 large employers by Crain's Chicago Business found that two-thirds of employers provide coverage after retirement.

- o A Minnesota survey of 410 organizations found that 56 percent offer benefits after retirement.

- o A Conference Board survey of 1400 companies in 1979 found that 68 percent extend some benefits to retirees.

What is the Cost of Coverage?

The only available evidence on costs of retiree health benefits across employers comes from specific employers and from consultants who work with employers to manage these costs. The rule of thumb among benefits consultants is that employers pay approximately 20 pecent of the health costs of retirees. According to experts, retiree health costs average $3,000 to $5,000 annually for those under age 65 and $600 to $1500 for those over age 65. Aggregate estimates of costs are provided below.

- o Joseph Califano, former Secretary of HEW and currently a Director of Chrysler Corp., during testimony before the Joint Economic Committee in April, 1984 estimated that for the Fortune 500 companies the unfunded liabilities for health benefits approaches $2 trillion, while the total assets for these companies is only $1.3 trillion.

- o Hewitt Associates, a benefits consulting firm estimates that "the typical employee will receive more dollars of health care after retirement than before retirement -- even though Medicare is covering part of the claims after age 65."

- o Atlantic Richfield Company, with 21,000 employees and 11,000 retirees in its oil company operations, estimates its health benefit costs to be $33 million annually for employees and $10 million for retirees. The average cost per employee is $1600 vs $900 for retirees; annual costs for early retirees are $2,000 vs. $625 for those 65 and older.

- o B.F. Goodrich in Akron, Ohio spends $20 million for retirees out of a total health bill of $64 million.

- Curtiss Wright closed its Patterson, New Jersey plant and 2,000 retirees lost their health benefits. At the time the plant was closed annual premiums paid by the company for these retirees was $1 million ($500 per retiree).

- A small manufacturing company employing only 800 workers attempted to eliminate its retiree health benefits. The United Auto Workers brought suit against the company and if the Court rules in favor of the union the total liability for these benefits may exceed the total assets of the company (approximately $50 million).

THE PROBLEM

In the past few years, thousands of retirees have lost their employer-sponsored health benefits and many more have had their benefits scaled back. Retirees are faced with two types of problems. One stems from a plant closing in their community which results in the termination of their health benefits. Several visible examples of this problem have received attention by the media in recent months, most notably the Crucible Steel plant closing in Midland, Pennsylvania by Colt Industries. In this case, the retirees and community residents organized themselves and mobilized national public attention on their predicament. The pressure on Colt Industries, a financially viable firm headquartered in New York, resulted in a partial restoration of the health benefits for retirees for one year. during this year, ongoing negotiations are to take place to decide the fate of retirees after the year period is over. In countless other communities the retirees who have lost benefits are not so fortunate.

The second type of predicament retirees find themselves in stems from a benefit redefinition by their employer. In this case, retirees retain some health coverage by their employer but it is reduced, often to coincide with reductions in the same plan for active employees. One example that has received some attention involves Bethlehem Steel Corporation in Bethlehem, Pennsylvania, where retiree cost-sharing was increased by the company for non-union retirees. The retirees at Bethlehem will now have to pay up to $1,000 a year out-of-pocket for their health care and 1,000 of these retirees have brought suit against the company claiming that Bethlehem violated an implied contract.

What are the Causes of the Problem?

Four important factors are at the heart of the crisis for retirees, their former employers and their union representatives. These factors include spiraling health care costs, early retirement trends, Medicare changes and the threat of new accounting rules for retiree health benefits. Each of these contributes to the growing problem in corporate retiree health care.

Rising health care costs. The spiraling costs of health care have received considerable attention in recent years and reams of material have been produced on the subject. Several salient points are worth mentioning.

- Americans are spending more than **$1 billion** a day on health care.

- Health care costs in general have risen **770 percent** since 1965; hospital costs rose **979 percent**, and physicians fees rose **700 percent.** During that same period, the consumer price index rose by only **242 percent.**

The specific health cost problems for employers are equally as dramatic. Health care premiums for many employers have been rising by 25% a year in recent years. In 1984, for example, Chrysler's health costs will exceed $400 million, up from $81 million in 1970. Chrysler's total health care bill now exceeds $550 for each car sold. Most employers are facing similar health care cost problems.

The cost increases for retiree health coverage are no less impressive. Unfortunately, there are no reliable national data on these costs so estimates must be based on individual employer estimates. For example, a major eastern steel manufacturer reports that retiree health costs were 3 percent of their total health bill in 1975; in 1983 they had risen to 31 percent of total health costs.

Early retirement. The trend toward earlier and earlier retirement, stimulated by lucrative pension plans and early retirement incentives by employers, has exacerbated the retiree health cost problem. Presently, only 18 percent of men and 8 percent of women over age 65 are in the labor force. Most workers retire well before age 65 and with the recent downturn in the economy, many employers increased the incentives for early retirement to avoid layoffs. Unfortunately, early retirement simply transfers the costs for employees from the payroll to pensions and post-retirement health and welfare benefits.

Ample evidence exists to suggest that premature retirement is unhealthy and that remaining actively employed is a hedge against certain kinds of ailments. Moreover, early retirement contributes to a loss of tax revenues, which are essential to keep the Medicare system solvent. Thus, when employers encourage early retirement they are not only adding to their own costs directly (pension, health benefits, etc.) but they are contributing to the funding problems of Medicare as well. All of these factors contribute to an emerging crisis for employers who have made a commitment — and who rely on Medicare to help meet that commitment — in order to provide health benefits for their retirees.

Medicare changes. There is a very close relationship between Medicare and employer-sponsored health benefits for retirees. Typically, employers provide a "carve out" plan for retirees in which Medicare's reimbursements are deducted from the company's obligations before the company health plan pays any benefits. In other cases, employers offer a "supplemental" plan, which merely provides specified additional coverage (similar to traditional Medigap policies) above Medicare's coverage. In both cases, any change in Medicare benefits, deductibles, coinsurance or premiums will have a direct effect on the health costs of employers.

For example, Chrysler pays for its retirees' Medicare deductible, as well as copayments for long term hospital stays. Since 1965, the hospital deductible has risen from $40 to $356. The most recent change in the deductible alone will cost Chrysler $1 million a year. If the eligibility age for Medicare is increased from 65 to 67, as has been proposed by the Social Security Advisory Council and other groups, Chrysler would be forced to pay an additional $100 million over the next five years. While Congress has not made major alterations in Medicare benefits this year, projections are that next year and for several years to come we are likely to see enormous changes that could increase employer costs substantially.

New rules. Employers have begun to pay attention to their post-retirement health care liability, in part, because of a recent proposal by the Financial Accounting Standards Board (FASB) which would modify the present "pay as you go" system by requiring employers to account for a retiree's future health care premiums during the period in which he is employed. This has forced employers to face the enormous unfunded liability of these future benefits. If we are to believe a 1983 Hewitt Associates report, which states that, "the typical employee will receive more dollars of health care after retirement than before retirement — even though Medicare is covering part of the claims after age 65," the FASB proposal portends a major shift in corporate thinking about retiree health benefits.

What Legal Protections Are There For Retirees?

Federal law does not mandate that health or other welfare benefits be maintained by an employer. Medical, surgical hospital or other health benefits provided by employers are covered by the Employee Retirement Income Security Act (ERISA), but no minimum standards are established for such benefits. ERISA ensures that adequate reserves are set aside for pension benefits to protect the retirement incomes of present and future retirees. No such funding requirements are established for retiree hospital, medical or other health benefits. The only requirement is that employers provide a clear description of the health plan (via a summary plan description or SPD) to retirees. Section 502 of ERISA does specify certain rights to participants and beneficiaries, such as the right to bring suit to recover benefits due under the terms of the plan, to enforce rights under the plan or to clarify rights to future benefits. Moreover, the fiduciary provisions of ERISA require that a plan fiduciary must administer these benefits prudently and in the best interests of participants and beneficiaries. Section 301 of the Labor-Management Relations Act of 1947 authorizes legal action where collectively bargained agreements are involved. Several important lawsuits have been filed under both of these statutes in attempts to restore or protect the "promised" health benefits for retirees.

Despite the absence of specific legislation protecting their health benefits, numerous court cases have called into question the legality of altering promised benefits after an individual is retired. Employers who have modified benefits for retirees have, in some cases, run into a hornet's nest of litigation. The question usually centers around the nature of the real or implied promise to retirees: was it for the life of the collectively bargained agreement; the life of the company, or the life of the retiree? Where the promise is vague, the courts have often concluded that benefits are to be paid for the life of the retiree. With health costs rising at an aveage of 15% annually and life expectancy increasing slightly each year, the notion of lifetime benefits frightens employers. Likewise, for retirees, the the mere threat of losing those benefits is equally frightening.

The following review of litigation on this issue provides some insights into the problem:

1. In 1972, Federal Mogul closed its Bower Roller Bearing plant in Detroit and discontinued health benefits for employees and retirees. The UAW filed suit and the Eastern District of Michigan Court ruled that the company must continue to pay the premiums for retiree health insurance. These premiums, however, were capped at April 1974 levels, with the additional premium payments being deducted from retiree pension checks.

2. When the UAW struck the Cadillac Malleable Iron Company in Cadillac, Michigan in 1981 the company terminated health insurance benefits for active employees commencing on the first day of the strike, but continued the benefits for retirees. In February, 1982, however, the company terminated benefits for retirees. The UAW sued the company under Section 301 of the Labor Management Relations Act. The District Court ruled that Cadillac must continue to provide benefits for its retirees. The case is on appeal in the Sixth Circuit.

3. When faced with health care bills rising at an annual rate of 17%, Bethlehem Steel Corporation redesigned its health benefit program for 16,000 nonunion retirees. In April, 1984, attorneys representing 1,000 retirees filed a class action suit claiming the company had broken an implied contract. The case is still pending.

4. In separate cases involving the UAW, employers were required by the courts to restore health benefits to retirees:

- o American Standard, Inc. must continue benefits for 70 retirees after closing its Columbus, Ohio plant;
- o Wellman Dynamics closed its plant and the courts have required it to continue health benefits for 25 retirees.
- o Yard-Man, Inc. was required by the court to continue benefits for 75 retirees after closing its Jackson, Missippi lawn mower plant.

SOLUTIONS

Protecting the health care benefits for present and future retirees requires a multi-pronged approach. System-wide health care cost-containment and ensuring the viability of Medicare are essential and must be the centerpiece of any proposed solution if it is to succeed.

Cost-containment. The most important component of the retiree health care problem is controlling the burgeoning costs of health care. Bringing costs under control would go a long way toward easing the pressure on employers to eliminate or scale back retiree benefits. Cost-containment efforts are presently underway in many communities and states:

- o state and community health care coalitions are devising strategies to lower health care costs;
- o corporations are attempting to negotiate better health care rates with health care providers;
- o the new DRG's for Medicare hospital reimbursement are an attempt to control costs in that program;

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- several states have enacted all-payors cost-containment legislation;
- HMO's, now reimburseable under Medicare, have become an important component of the cost-containment strategy, and
- individual employer initiatives, such as worksite wellness, are designed to reduce corporate health costs in the future.

On a national level, legislation has been introduced to bring health care costs under control and thereby protect the solvency and integrity of the Medicare system. (The most notable of these to date are S.2424 and H.R. 4870, introduced by Senator Kennedy and Rep. Gephardt, and S. 2752, introduced by Senator Heinz. Rep. Roybal, Chairman of the House Aging Committee, is also preparing legislation to hold down health care costs and to protect the retirees from declines in the quality of health care.)

Maintain Medicare benefits. Medicare is a critical component of the protection available to retirees. Any attempt to contol costs by decreasing the benefits to Medicare beneficiaries or increasing copayments, deductibles and premiums will only shift the costs to employers or to the elderly themselves. Employers who already are having difficulties meeting their obligations to retirees will be further strained by any Medicare reductions.

Legal protections. There is no consensus as to whether or what kind of legislation is necessary to protect retiree health benefits. Several options are available:

- Amend Title I of the Employee Retirement Income Security Act (ERISA) to declare that unless otherwise specified, health and welfare benefits promised to retirees are provided for the life of the retiree. Legislation to accomplish this was introduced recently by Rep. Brooks (H.R. 5475) in response to pleas by retirees of Gulf Oil who are fearful that their benefits will be terminated because of the merger with SoCal. The legislation covers life insurance, health benefits and supplemental pension benefits.
- Amend Title IV of ERISA to require that health benefits be funded in advance (similar to the requirements now imposed on pension plans). No legislation has been introduced to date to require pre-funding of health benefits, but many experts agree that some type of pre-funding — phased in over a long period of time — is necessary to ensure that benefits are available for future retirees.

Non-legislative solutions. A variety of cost-management strategies for retiree health care are available to employers. Few of these have been implemented, largely because employers have only recently become aware of the magnitude of the problem. Those that have been implemented are often simply extensions of increased cost-sharing programs that were implented for employees. Increasing the out-of-pocket costs for health care consumers is in vogue now as a way of decreasing utilization. Regardless of the merits of this argument, such cost increases for retirees, who must live on fixed and limited incomes, can be a tremendous burden and may result in a deferral of health care utilization which could increase the future costs of health care. Other, less onerous solutions, include:

- Include retirees in corporate-sponsored **wellness programs** now being offered for many employees. Few employers have done this to date, but those that have (System Development Corporation and IBM) have found this to be an

inexpensive option that they are hopeful will produce cost-savings in the future. One obvious problem is that retirees are often disbursed around the country making it more difficult for them to participate in company physical fitness and wellness programs.

- Offer and promote utilization of **HMO's for retirees.** Employers, especially large ones, are in a good position to negotiate with HMO's and to demand that they accept their retirees as a condition of signing a contract for the company's employees. HMO's are a recognized cost saving mechanism and now that Medicare will reimburse for HMO utilization this becomes an increasingly attractive option for retirees.

- Provide **flexible employment opportunities** for retirees who wish to remain in or reenter the workforce. Retirees who are actively employed are not only contributing their productive efforts to the company, but are more likely to remain healthy longer. The absence of employment opportunities, especially part-time jobs, is an economic hardship for many retirees, which in turn contributes to diminished health.

- Retiree **health education programs**, such as those now in vogue for employees, would enable retirees to become better health care consumers and presumably to lower their costs of health care. Most employers have established mechanisms for communicating with retirees (mailing pension checks) which would make it relatively easy to communicate health education material.

- Develop **health care monitoring activities** to provide retirees with meaningful roles that serve the dual purpose of ensuring cost-effective and high quality health care for themselves and their peers and allows these retirees to remain active in meaningful roles. Retirees with backgrounds in health care-related fields would be especially suited to such a role.

CONCLUSION

The enormous problem of lost health benefits for retirees and the spiraling costs of health care must be met head on now before the problem becomes more severe. There is no single best strategy for solving this problem, but rather a multi-pronged approach must be implemented in order to secure a healthy future for America's retirees.

Perhaps the most important lesson from an analysis of the problem of threatened health benefits for retirees is the understanding that there is commonality of interest between retirees and business. If business is to make good on its promises to retirees, and there is every reason to believe that most businesses feel strongly about doing so, they must work with retiree organizations and the Congress to reach a viable solution to the rising costs of health care and the funding difficulties facing Medicare. Any approach to these problems which shifts costs from Medicare to employers or retirees is not in the best interest of either group.

APPENDIX 2

WILLIAM M. MERCER-Meidinger

Anthony J. Gajda

June 29, 1984

The Honorable Edward R. Roybal
Chairman
Select Committee on Aging
House Annex #1 Room 712
300 New Jersey Avenue, SE
Washington, D. C. 20515

Dear Congressman Roybal:

At the conclusion of the Select Committee's hearings held on June 27, 1984, you invited the panelists to submit comments about the use and value of cost containment initiations. Earlier in the hearings you posed a question directly to me about the different forms that cost containment can take.

In this regard, I have enclosed a copy of a presentation that I recently made that discusses the dynamics of health care markets and the implications for private sector employee benefit plans. Private sector employee benefit plans will pay nearly $100 billion for employee health care this year and, as a consequence, the corporate sector has a keen interest in developments in the health care industry.

In my presentation, I discuss the origins of our apparently relentless health care price inflation, near-term and long-term prospects, along with cost containment initiations that can be taken by business to begin to insulate employee benefit plans from further attacks of inflation.

This paper was then used as the springboard for a presentation to twenty hospitals in the New York Area about some material and even radical changes that I believe will take place in the health care industry before the end of this decade.

You will find a comprehensive listing of cost containment initiatives appended to the paper. It is from this list that we as consultants, design programs for our clients. Inasmuch as this list contains no detail, I would be delighted to discuss any one or all of the techniques with you or members of the Committee staff.

I will close by thanking you and the Committee for the opportunity to present our thoughts on the issue of post-retirement medical benefits at your hearings.

Sincerely,

Tony Gajda

cc: Mr. Steve McConnell

1211 Avenue of the Americas • New York, NY 10036 • 212 997-7130

COST CONTAINMENT: AN ECONOMIST'S VIEW

PRESENTATION

made at the

WILLIAM M. MERCER - MEIDINGER, INCORPORATED

BREAKFAST SEMINAR

MARCH 29, 1984

By: Anthony J. Gajda
Economist

William M. Mercer-Meidinger, Inc.
1211 Avenue of the Americas
New York New York 10036
(212) 997-7130

AN ECONOMIST'S VIEW OF HEALTH CARE COST CONTAINMENT DOES NOT DIFFER MUCH FROM THE VIEW OF A PLAN SPONSOR OR A BENEFIT PLAN MANAGER. AN ECONOMIST'S VIEW OF HEALTH CARE COST CONTAINMENT WILL GENERALLY SUPPORT THE VARIETY OF INITIATIVES BEING TAKEN TODAY.

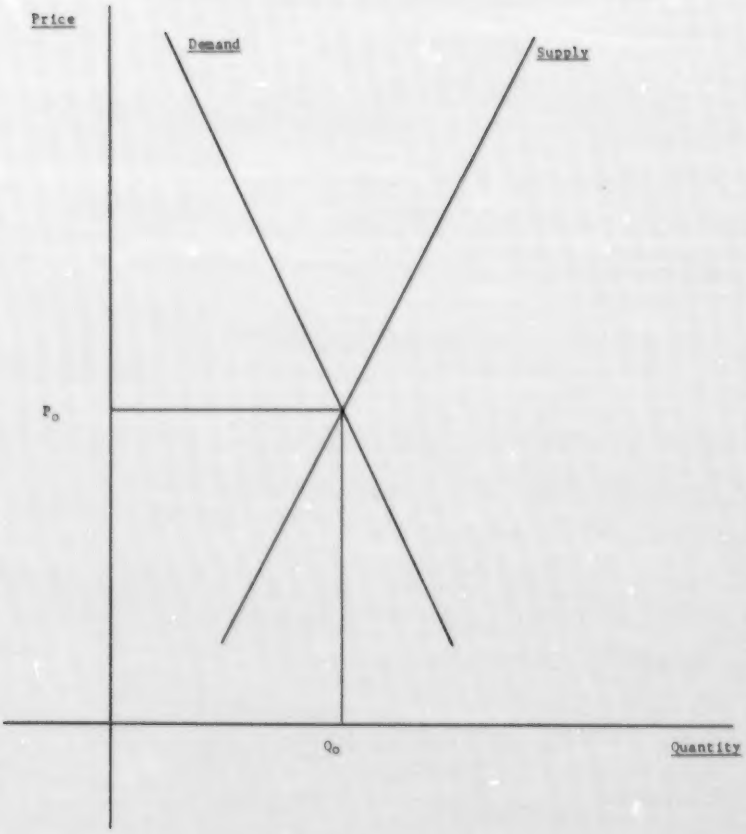
IN ANOTHER SENSE, THOUGH, BECAUSE AN ECONOMIST WILL EXAMINE COST CONTAINMENT IN A LARGER CONTEXT THAN A SINGLE BENEFIT PLAN OR A GROUP OF PLANS, THE DYNAMICS OF HEALTH CARE MAY SUGGEST THAT EVEN GREATER OR MORE AGGRESSIVE COST CONTAINMENT INITIATIVES MAY HAVE TO BE TAKEN IN THE FUTURE.

THE FRAMEWORK OF AN ECONOMIST'S ANALYSIS OF THE HEALTH CARE SYSTEM IS CALLED COMPARATIVE STATICS WHICH IS USUALLY MORE RECOGNIZABLE AS SUPPLY AND DEMAND ANALYSIS.

FIGURE 1 SHOWS A MARKET FOR HEALTH CARE.

THE DEMAND CURVE FOR HEALTH CARE REFLECTS THE REASONABLE OBSERVATION THAT CONSUMERS WILL DEMAND LESS HEALTH CARE SERVICES AT HIGH PRICES THAN THEY WILL AT LOW PRICES AND THE SUPPLY CURVE REFLECTS THE EQUALLY REASONABLE OBSERVATION THAT PROVIDERS WILL SUPPLY MORE HEALTH CARE SERVICES AT HIGH PRICES THAN THEY WILL AT LOW PRICES.

FIGURE 1



THE FACT THAT THE DEMAND CURVE IS RELATIVELY STEEP SUGGESTS THAT THE DEMAND CURVE FOR HEALTH CARE IS INELASTIC - THAT THE DEMAND FOR HEALTH CARE, LIKE FOOD, IS NOT VERY SENSITIVE TO PRICE CHANGES.

THE PAST

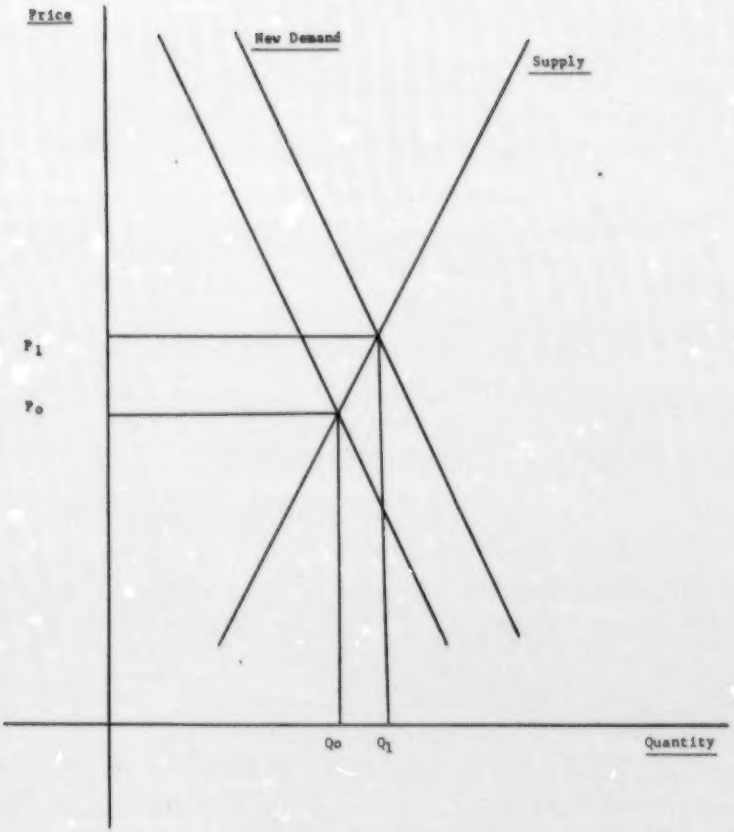
IT IS USEFUL TO EXAMINE THE HEALTH CARE MARKET FOR THE PAST 20 YEARS IN THIS SUPPLY AND DEMAND FRAMEWORK IN ORDER TO UNDERSTAND THE CONTEMPORARY HEALTH CARE MARKET AND THE SUPPLY AND DEMAND FORCES THAT EXIST TODAY.

IF FIGURE 1 DESCRIBES THE HEALTH CARE MARKET OF THE EARLY - 1960'S, THEN FIGURE 2 DESCRIBES THE HEALTH CARE MARKET OF THE LATE - 1960'S, AFTER APPROXIMATELY 18 MILLION OLDER ADULTS BECAME INSURED BY MEDICARE AND MILLIONS OF OTHERS BECAME INSURED BY MEDICAID.

BECAUSE MILLIONS OF CONSUMERS COULD NOW OBTAIN HEALTH CARE SERVICES FOR THE COST OF A DEDUCTIBLE AND CO-INSURANCE OR AT NO OUT-OF-POCKET COST AT ALL, THEIR DEMAND FOR HEALTH CARE INCREASED.

FIGURE 2 SHOWS AN INCREASE IN CONSUMER DEMAND FOR HEALTH CARE BY A SHIFT OF THE DEMAND CURVE.

FIGURE 2



AT THE INTERSECTION OF THE SUPPLY CURVE AND THE NEW DEMAND CURVE, A GREATER QUANTITY OF HEALTH CARE SERVICES ARE PRODUCED AT A HIGHER COST.

NORMALLY, IF THERE IS A QUANTUM INCREASE IN THE DEMAND FOR A GOOD OR A SERVICE, MARKETS WILL RESPOND WITH AN INCREASED SUPPLY OF THAT GOOD OR SERVICE. IN THIS SENSE, HEALTH CARE MARKETS RESPONDED IN A NORMAL MANNER.

TABLE 1 SHOWS THE NUMBERS OF PHYSICIANS IN THE U.S. IN 1960, 1970 AND 1980.

TABLE 1

YEAR	PHYSICIANS	PHYSICIANS PER 10,000 POPULATION	POPULATION PER PHYSICIAN
1960	251,900	13.6	735
1970	326,500	15.6	641
1980	457,500	19.7	508

TABLE 2 SHOWS THE NUMBERS OF HOSPITAL BEDS PROVIDING ACUTE CARE SERVICES IN 1960, 1970, AND 1980.

TABLE 2

YEAR	ACUTE CARE HOSPITAL BEDS	HOSPITAL BEDS PER 1,000 POPULATION
1960	639,057	3.46
1970	848,232	4.07
1980	992,020	4.37

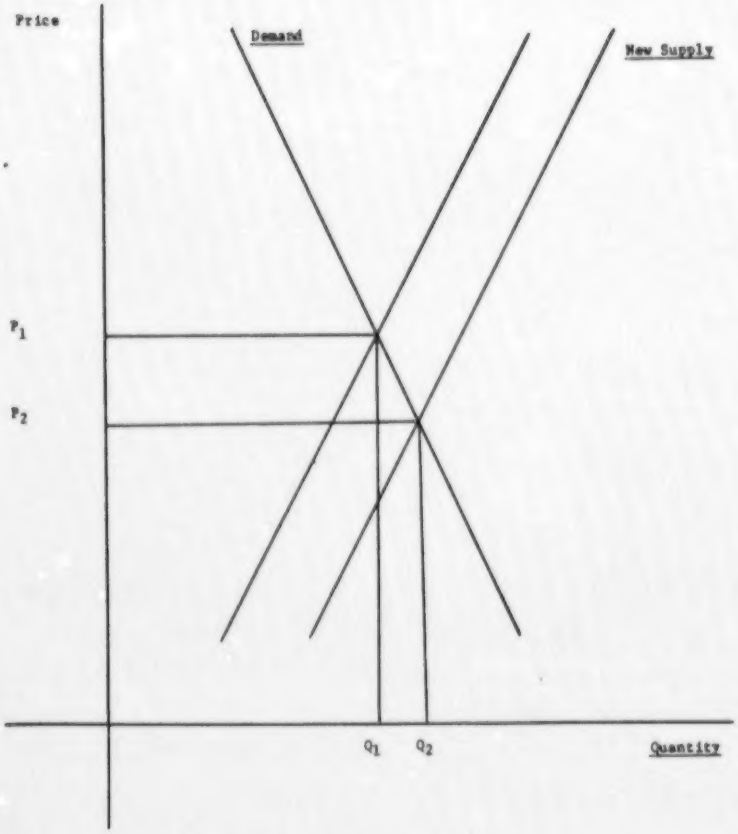
FIGURE 3 DESCRIBES THE EFFECT OF INCREASES IN THE SUPPLY OF PHYSICIANS AND INCREASES IN THE SUPPLY OF HOSPITAL BEDS.

AS THE SUPPLY OF HEALTH CARE PROVIDERS INCREASES, THE SUPPLY CURVE SHIFTS DOWNWARD. AT THE INTERSECTION OF THE NEW SUPPLY CURVE AND THE DEMAND CURVE, GREATER AMOUNTS OF HEALTH CARE SERVICES WILL BE PRODUCED AT A LOWER COST.

THE DIFFICULT PROBLEM THAT WE FACE, THOUGH, IS THAT WITH THE GROWTH IN SUPPLY WE HAVE SEEN A GREATER QUANTITY OF HEALTH CARE SERVICES PRODUCED, BUT WE HAVE NOT SEEN THOSE SERVICES PRODUCED AT A LOWER COST. INDEED WE HAVE EXPERIENCED JUST THE REVERSE - APPARENTLY RELENTLESS INCREASES IN THE PRICE OF HEALTH CARE.

SINCE WE HAVE OBVIOUSLY HAD AN INCREASE IN THE SUPPLY OF HEALTH CARE PROVIDERS, FIGURE 3 MUST NOT TELL THE WHOLE STORY.

FIGURE 3



THE PRESENT

FIGURE 4 IS AN EXPLANATION OF THE DYNAMICS OF THE HEALTH CARE MARKET THAT WILL SEEM REASONABLE TO MOST PERSONS WHO ARE EVEN TANGENTIALLY INVOLVED WITH HEALTH CARE.

FIGURE 4 DESCRIBES A HEALTH CARE MARKET IN WHICH SUPPLY HAS INCREASED BUT IN WHICH INCREASES IN THE DEMAND FOR HEALTH CARE HAVE SWAMPED THE EXPECTED PRICE REDUCTIONS ASSOCIATED WITH INCREASES IN SUPPLY.

THERE IS SOME EVIDENCE THAT FIGURE 4 IS A GOOD INTERPRETATION OF WHAT HAS HAPPENED IN THE HEALTH CARE SECTOR.

FIRST, THE ARRAY OF HEALTH CARE SERVICES TODAY IS GREATER AND MORE SOPHISTICATED THAN EVERY BEFORE. SOME, LIKE THE USE OF MEDICATION INSTEAD OF SURGERY TO TREAT STOMACH AND DUODENAL ULCERS, HAVE A DAMPENING EFFECT ON HEALTH CARE COSTS. BUT MANY MORE OTHERS HAVE A REVERSE EFFECT. ULTRASOUND, BY-PASS SURGERY, CAT SCANNERS AND THE LIKE HAVE TENDED TO INCREASE COSTS. DEFENSIVE MEDICINE HAS LED TO CHANGES IN THE PRACTICE OF MEDICINE. MORE AWARENESS OF THE ROLES OF NUTRITION, SOCIAL SERVICES, ETC. IN THE MAINTENANCE OF HEALTH HAVE LED TO WHOLE NEW DEPARTMENTS IN HOSPITALS. ONE MEASURE OF THE

GROWING COMPLEXITY OF HEALTH CARE SERVICES CAN BE SEEN IN TABLE 3.

TABLE 3 SHOWS THE NUMBER OF HOSPITAL EMPLOYEES PER 100 PATIENT DAYS DURING 1960, 1970 AND 1980.

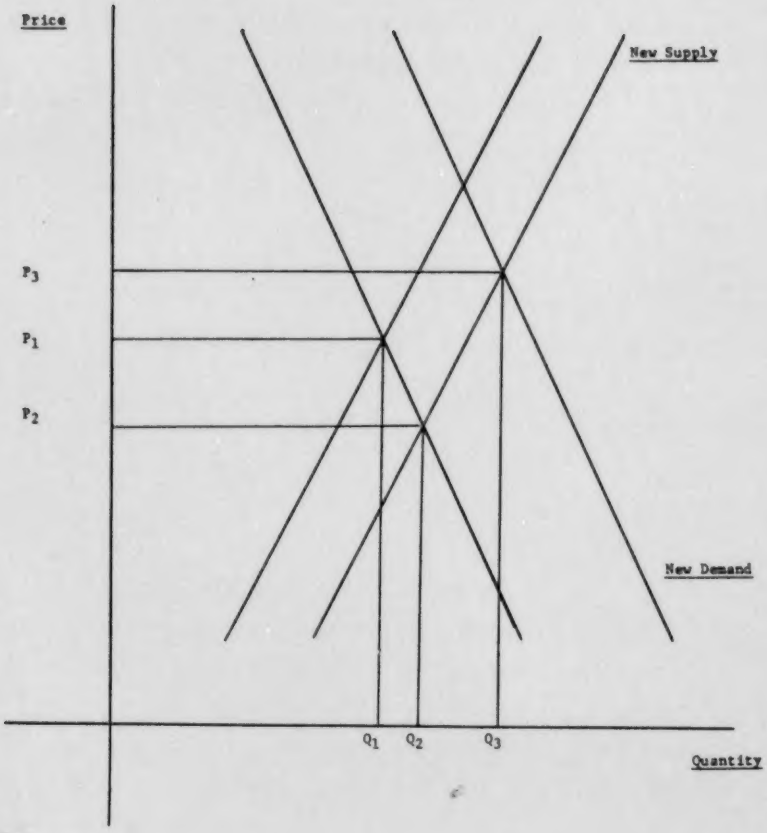
TABLE 3

YEAR	HOSPITAL EMPLOYEES PER 100 PATIENT DAY
1960	226
1970	302
1980	394

A SECOND REASON THAT MIGHT EXPLAIN THE INCREASED DEMAND FOR HEALTH CARE IS THE EFFECT OF EMPLOYEE BENEFIT PLAN DESIGNS.

DURING THE 1970'S MANY EMPLOYEE BENEFIT PLANS WERE IMPROVED BY ADDING NEW BENEFITS, BY IMPROVING EXISTING BENEFITS AND BY INCREASING THE BENEFIT PLAN SHARE OF HEALTH COSTS. IN OTHER INSTANCES, BENEFIT PLANS WERE NOT CHANGED AT ALL. BUT, EVEN NO CHANGE CAN RESULT IN INCREASED COSTS. CONSIDER, FOR EXAMPLE, THAT A MAJOR MEDICAL PLAN WITH A $100 DEDUCTIBLE IN 1970 WOULD HAVE HAD TO BE INCREASED TO APPROXIMATELY $500 - $600 IN 1985 IN ORDER TO PRESERVE THE EMPLOYER-EMPLOYEE COST SHARES OF 1970.

FIGURE 4



A THIRD REASON THAT MIGHT EXPLAIN FIGURE 4 IS THE BELIEF BY MANY THAT AN INCREASE IN THE SUPPLY OF PHYSICIANS DOES NOT NECESSARILY LEAD TO A REDUCTION IN THEIR FEES. THIS BELIEF, WHICH IS EMBODIED IN THE THEORY OF COLLECTIVE MONOPOLY AND TARGET INCOME CAN BE BEST ILLUSTRATED BY THE CLICHE' THAT "WHEN PEOPLE ARE SICK THEY DON'T SHOP FOR DOCTORS AND WHEN THEY'RE HEALTHY THEY DON'T CARE". IF DOCTORS HAVE A TARGET INCOME AND ADJUST THEIR FEES TO PRODUCE THAT INCOME, THEN HEALTH CARE COSTS WILL CONTINUE THEIR INEXORABLE RISE.

A FOURTH REASON THAT MIGHT EXPLAIN FIGURE 4 IS THE FACT THAT MANY BENEFIT PLANS REIMBURSE HEALTH CARE SERVICES ON THE BASIS OF THE COST OF THOSE SERVICES. THERE HAS BEEN LITTLE REGARD DURING THE PAST TWENTY YEARS FOR AUDITING COSTS OR REDUCING COSTS.

A FIFTH REASON THAT MIGHT EXPLAIN FIGURE 4 IS THE FACT THAT BENEFIT PLAN MEMBERS HAVE LITTLE OR NO INCENTIVE TO CHANGE THEIR HEALTH CARE CONSUMPTION HABITS TO REDUCE COSTS. IN MANY BENEFIT PLANS TODAY, EMPLOYEES MAY STILL INCUR LOWER OUT-OF-POCKET EXPENSES IF THEY ARE HOSPITALIZED THAN IF THEY ARE NOT HOSPITALIZED, WHILE THE DIFFERENCE BETWEEN INPATIENT AND OUTPATIENT CARE CAN BE THOUSANDS OF DOLLARS OF BENEFIT PLAN PAYMENTS.

THERE ARE STILL OTHER REASONS THAT MIGHT EXPLAIN FIGURE 4.

BUT HAVING EXPLAINED WHY HEALTH CARE PRICES HAVE CONTINUED TO RISE AND TO OVERRIDE COUNTERVAILING FORCES, THERE ARE STILL OTHER FACTORS AT WORK THAT MAY HAVE IMPORTANT EFFECTS ON THE HEALTH CARE SYSTEM AND HEALTH CARE MARKETS.

HEALTH PLANNERS AND POLICY MAKERS CATEGORIZE THESE FORCES AS EITHER COMPETITIVE OR REGULATORY.

THE IMPRESSION THAT IS GIVEN BY THE COMPETITION VS. REGULATION ISSUE IS THAT THERE IS SOME CHOICE IN POLICY AVAILABLE. IN FACT, COMPETITIVE AND REGULATORY FORCES HAVE ALWAYS BEEN AT WORK, ARE WORKING NOW AND WILL CONTINUE TO WORK IN THE FUTURE.

REGULATION HAS TAKEN THE PRINCIPAL FORMS OF CAPITAL COST CONTROL AND REIMBURSEMENT RATE REGULATION.

UNDER PUBLIC LAW 93-641, THE FEDERAL GOVERNMENT ESTABLISHED THE REQUIREMENT THAT A QUANTITATIVE AND QUALITATIVE NEED MUST EXIST IN A COMMUNITY BEFORE A CAPITAL EXPENDITURE CAN BE AUTHORIZED. THIS PROCESS,

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THE APPLICATION AND APPROVAL OF CAPITAL EXPENDITURES, IS CALLED THE CERTIFICATE OF NEED.

UNDER A VARIETY OF PROSPECTIVE PAYMENT SYSTEMS OPERATED BY STATE HEALTH DEPARTMENTS SOME CONTROL HAS BEEN EXERCISED OVER THE GROWTH OF HOSPITAL OPERATING EXPENSES. THE FEDERAL GOVERNMENTS CONVERSION TO A DIAGNOSIS RELATED GROUP (DRG) REIMBURSEMENT SYSTEM IS, IN ALL LIKELIHOOD, THE FIRST OF MANY CONVERSIONS TO THE DRG SYSTEM BY MEDICAID, BLUE CROSS PLANS AND PRIVATE PLANS.

COMPETITION IS GENERALLY REPRESENTED BY THE EXISTENCE OF TWO OR MORE DELIVERY SYSTEMS, SUCH AS CONVENTIONAL INSURANCE, HMO'S AND PPO'S. COMPETITION AMONG THESE PLANS FOR INCREASED ENROLLMENT IS EXPECTED TO CONSTRAIN COST GROWTH.

SIMILARLY, EFFORTS BY THE FEDERAL GOVERNMENT TO TAX HEALTH INSURANCE PREMIUMS ABOVE SOME THRESHOLD IS EXPECTED TO INDUCE EMPLOYEES TO SHOP FOR LESS EXPENSIVE BENEFIT PLANS. FINALLY, AN ALTERNATIVE APPROACH THAT IS NOT AVAILABLE TO MANY PLAN SPONSORS IS THE COMPETITIVE BIDDING PROCESS THAT WAS USED BY CALIFORNIA FOR SELECTING PARTICIPANTS IN ITS MEDICAID PROGRAM.

IF THE HEALTH CARE MARKET EXPANDED TO ACCOMMODATE MEDICARE AND MEDICAID AND THE GROWTH OF EMPLOYEE BENEFIT PLANS, HOW WILL THE MARKET ADJUST TO THE GOVERNMENT AND BUSINESS CONCERNS ABOUT EXTRAORDINARY PRICE INFLATION?

THE ANSWER TO THAT THE SYSTEM IS DOING LITTLE TO ACCOMMODATE THESE CONCERNS.

IF GROWTH IN THE NUMBER OF HOSPITAL BEDS CAN BE REGARDED AS HORIZONTAL GROWTH, THEN THE FEDERAL AND STATE PLANNING EFFORTS AND SOME AGGRESSIVE CONSUMER COUNCILS WILL SLOW AND STOP HORIZONTAL GROWTH. HOWEVER, IF INCREASING SOPHISTICATION OF HOSPITAL SERVICES, PRIMARILY ON THE TECHNOLOGY FRONT, IS REGARDED AS VERTICAL GROWTH, THEN THERE IS LITTLE PROSPECT FOR SLOWING VERTICAL GROWTH. CLEARLY, THE DRG SYSTEM SHOULD WORK TO SLOW DOWN VERTICAL GROWTH, BUT THE JURY IS STILL OUT.

IN THE PHYSICIAN SECTOR, PROSPECTS FOR ACCOMMODATING COST CONCERNS ARE LESS PROMISING.

IF NO NEW MEDICAL SCHOOLS ARE OPENED, THE SUPPLY OF PHYSICIANS WILL STILL CONTINUE TO GROW.

TABLE 4 SHOWS THE EXPECTED SUPPLY OF PHYSICIANS FOR THE YEARS 1990 AND 2000.

TABLE 4

YEAR	PHYSICIANS	PHYSICIANS PER 10,000 POPULATION	POPULATION PER PHYSICIAN
1980	457,500	19.7	508
1990	591,200	24.3	412
2000	704,700	27.1	369

WE'VE PROBABLY SEEN TWO VERY DIVERGENT PHENOMENA ASSOCIATED WITH THE GROWTH OF PHYSICIAN SUPPLY.

FIRST, THERE HAS BEEN A CONSTANT INCREASE IN BOTH THE NUMBER OF SPECIALTY - TRAINED PHYSICIANS AND THERE HAS BEEN A GROWTH IN SUBSPECIALTY MEDICAL PRACTICE.

SECOND, WE HAVE ALSO SEEN AN INCREASE IN ALTERNATIVE PRACTICE PATTERNS WITH A GROWTH IN THE HEALTH MAINTENANCE ORGANIZATION MODEL AND THE ADVENT OF THE PREFERRED PROVIDER ORGANIZATION (PPO) AND EXCLUSIVE PROVIDER ORGANIZATION (EPO).

THE FIRST PHENOMENON, SPECIALIZATION, IS GENERALLY REGARDED AS COST-INCREASING, WHILE THE SECOND IS REGARDED AS COST-REDUCING.

IT IS LIKELY THE PHYSICIAN SPECIALIZATION WILL CONTINUE AND IT IS LIKELY THAT ALTERNATIVE PRACTICE PATTERNS WILL CONTINUE TO GROW IN THOSE AREAS IN WHICH PHYSICIAN CONCENTRATIONS ARE HIGH.

A FEW OBSERVATIONS AT THIS POINT WILL HIGHLIGHT SOME OF THE INTERNAL DIFFICULTIES THAT THE HEALTH CARE SYSTEM IS FACING - SOME WILL BENEFIT THE SPONSORS OF BENEFIT PLANS WHILE OTHERS WILL NOT.

THE GROWTH OF THE PHYSICIAN SUPPLY MAY LEAD TO ACTIONS BY ESTABLISHED PRACTITIONERS TO PROTECT THEIR MARKET SHARES. THIS PROTECTION CAN TAKE THE FORM OF LIMITING HOSPITAL PRIVILEGES AND CHARGING HIGH FEES FOR THE SALE OF AN ESTABLISHED PRACTICE. IF HOSPITAL PRIVILEGES CAN BE SUCCESSFULLY DENIED, THEN THOSE PHYSICIANS WITH PRIVILEGES WILL POSSESS GREATER ABILITY TO EXERCISE MONOPOLISTIC FEE-SETTING. AND, IF NEWLY PRACTICING PHYSICIANS MUST PURCHASE EXISTING PRACTICES AT HIGH PRICES, THEN THEIR FEES WILL REFLECT THIS ACQUISITION COST.

OF COURSE, IF NEWLY-PRACTICING PHYSICIANS ARE BLOCKED FROM ENTERING THE SYSTEM, THOSE PHYSICIANS WILL HAVE A GREATER INCENTIVE TO PARTICIPATE IN AND INNOVATE THE ALTERNATIVE DELIVERY SYSTEMS.

A FINAL POINT BEFORE MOVING ON IS THE APPARENT CLASH BETWEEN REGULATION AND COMPETITION.

HMO'S HAVE HISTORICALLY PRODUCED HEALTH CARE WITH A RELATIVELY LOW RELIANCE ON INPATIENT CARE AND .HAVE EXHIBITED BOTH LOWER ADMISSION RATES AND LOWER LENGTHS OF STAY. WITH THE ADVENT OF DRG'S, HMO'S MAY LOSE THE ADVANTAGE OF LOWER LENGTHS OF STAY FOR MEDICARE - ELIGIBLES AND FOR OTHER CLASSES OF ENROLLESS AS THEY COME UNDER THE DRG. CONSEQUENTLY, A REGULATORY EFFORT MAY DIMINISH A BENEFIT OF THE COMPETITIVE EFFORT.

THE CHALLENGE

CLEARLY, THERE ARE MANY CHANGES TAKING PLACE IN THE HEALTH CARE SYSTEM - MANY FORCES ARE AT WORK - SOME RAISING COSTS WHILE OTHERS REDUCE COSTS.

BEFORE ADDRESSING COST CONTAINMENT DIRECTLY, CONSIDER THE PROBLEM THAT MUST BE FACED.

TABLE 5 IS A MATRIX OF CURRENT HEALTH CARE COSTS AND DIFFERENT INFLATION RATES.

TABLE 5

CURRENT MONTHLY BENEFIT COST	TEN-YEAR BENEFIT EXPENDITURES BASED ON ANNUAL INFLATION OF: 12%	14%	16%
$ 75	15,793	17,404	19,189
100	21,057	23,205	25,585
125	26,321	29,006	31,981
150	31,585	34,807	38,377
175	36,850	40,609	44,774
200	42,114	46,410	51,170

THE CHALLENGE OF ADDRESSING RISING COSTS IS LARGE BUT SO ARE THE REWARDS FOR SUCCESS.

AND THERE ARE LITERALLY DOZENS OF TECHNIQUES FOR MEETING THE CHALLENGE.

THESE TECHNIQUES CAN BE GROUPED INTO THREE CATEGORIES:

1. COST MANAGEMENT
2. COST SHIFTING
3. COST REDUCTION

COST MANAGEMENT INCLUDES SUCH TECHNIQUES AS:

- TIGHTENING REASONABLE AND CUSTOMARY GUIDELINES,
- CHANGING FUNDING VEHICLES,
- USING ASO VEHICLES AND 501(c)(9) TRUSTS, AND,
- AUDITING ADMINISTRATORS AND HOSPITALS.

THE ATTRACTIVE CHARACTERISTIC OF THESE AND OTHER COST MANAGEMENT TECHNIQUES IS THAT THEY REQUIRE VERY LITTLE, IF ANY, CHANGES FOR EMPLOYEES. WITH ONE OR TWO POSSIBLE EXCEPTIONS, COST MANAGEMENT CHANGES CAN BE UNDERTAKEN UNILATERALLY BY PLAN SPONSORS.

GENERALLY, IN A CONVENTIONALLY - INSURED BENEFIT PLAN, AN AGGRESSIVE COST MANAGEMENT APPROACH CAN PROBABLY

REDUCE COSTS BY AT LEAST TWO PERCENTAGE POINTS. REFERRING BACK TO TABLE 5 WILL GIVE SOME PERSPECTIVE OF A 2% SAVINGS OVER TEN YEARS.

THE SECOND GROUP OF TECHNIQUES IS COST-SHIFTING AND INCLUDES SUCH CHANGES AS:

- INCREASING DEDUCTIBLES,
- INCREASING EMPLOYEE CO-PAYMENTS, AND,
- INCREASING EMPLOYEE CONTRIBUTIONS.

THE ATTRACTIVE CHARACTERISTIC OF COST-SHIFTING IS THAT IT PRODUCES AN IMMEDIATE AND DIRECT REDUCTION OF EMPLOYER COSTS.

LESS ATTRACTIVE THOUGH IS THE FACT THAT COST-SHIFTING CAN NOT USUALLY BE ACCOMPLISHED WITHOUT SOME RESENTMENT OR RESISTANCE FROM EMPLOYEES. EMPLOYEES CAN ARGUE

PASSIONATELY THAT THEY ARE NOT RESPONSIBLE FOR THE COST OF SURGERY OR OF A HOSPITAL CONFINEMENT AND THAT COST-SHIFTING IS THE ABROGATION OF A MORAL CONTRACT. AND, COST SHIFTING DOES NOT ADDRESS SYSTEM-WIDE HEALTH COST PROBLEMS. IT SIMPLY TRANSFERS COSTS FROM EMPLOYERS TO EMPLOYEES.

TABLE 5 WILL AGAIN DEMONSTRATE THE TEN-YEAR SAVINGS ASSOCIATED WITH, FOR EXAMPLE, A $25 PER MONTH SHIFT IN COSTS.

THE FINAL GROUP OF TECHNIQUES AVAILABLE IS COST REDUCTION.

COST REDUCTION TECHNIQUES ARE THE MOST INTERESTING TECHNIQUES BECAUSE THEY OFFER THE OPPORTUNITY OF SAVINGS WHILE, AT THE SAME TIME, IMPROVING THE QUALITY OF HEALTH CARE AVAILABLE TO EMPLOYEES.

COST REDUCTION TECHNIQUES INCLUDE, AMONG OTHERS:

- ALTERNATE CARE FACILITIES,
- AMBULATORY SURGERY,
- WELLNESS PROGRAMS, AND
- MANAGED HEALTH CARE.

COST REDUCTION REQUIRES A HIGHER LEVEL OF PLAN SPONSOR INVOLVEMENT IN EMPLOYEE HEALTH CARE THAN THE OTHER TECHNIQUES. COST REDUCTION IS A PROCESS, UNLIKE COST SHIFTING, THAT REQUIRES EMPLOYEE BEHAVIOR CHANGE, CONTINUING EDUCATION AND COMMUNICATION. BUT THE INVESTMENT OF EFFORT CAN PRODUCE THE DIVIDENDS OF SAVINGS AND IMPROVED EMPLOYEE HEALTH WITHOUT THE DISADVANTAGES OF COST SHIFTING.

THE FUTURE

THE MOST IMPORTANT CHANGE THAT WILL TAKE PLACE, AND IS BEGINNING TO TAKE PLACE ALREADY IN THE HEALTH CARE SYSTEM IS THE SHIFT OF ROLES IN THE SYSTEM.

FOR DECADES, PROVIDERS HAVE BEEN THE PRINCIPAL PLAYERS IN THE HEALTH CARE SYSTEM - PHYSICIANS AND HOSPITALS HAVE DISPENSED CARE TO MEDICALLY UNSOPHISTICATED CONSUMERS. CONSUMERS THEN SENT THESE CLAIMS TO THE INSURANCE CARRIER. THE INSURANCE CARRIER PAID THE CLAIMS AND THEN SENT THE BILL TO THE PLAN SPONSOR, A BUSINESS OR A GOVERNMENT.

BUSINESS AND GOVERNMENT WERE ALMOST CAPTIVE PARTNERS IN THE PROCESS. IF BUSINESS WANTED TO BUY A BENEFIT PLAN, INSURANCE CARRIERS HAD A SMALL NUMBER OF OFF-THE-SHELF PRODUCTS THAT A BUSINESS COULD BUY. IF GOVERNMENT

WANTED A BENEFIT PLAN, IT HAD TO BALANCE ITS NEEDS AGAINST ORGANIZATIONS REPRESENTING PROVIDERS AND THE INTERESTS OF PROVIDERS:

IN A VERY REAL SENSE, BUSINESS AND GOVERNMENT, WHICH PAY $1/3 TRILLION FOR HEALTH CARE, WERE TOLD HOW TO PROVIDE THAT HEALTH CARE.

DURING THE PAST FEW YEARS, BUSINESS AND GOVERNMENT HAVE BEGUN TO EXERCISE THE AUTHORITY THAT COMES WITH PAYING THE BILL.

GOVERNMENT HAS TAKEN A BIG STEP BY CONVERTING TO DRG'S AND BUSINESS HAS BEGUN TO TELL INSURANCE CARRIERS HOW THEY WANT THEIR BENEFITS PACKAGE DESIGNED.

HOSPITALS WILL BECOME MORE ACCOUNTABLE AND, THROUGH HOSPITALS, PHYSICIANS WILL BE FORCED TO RECONSIDER LONG-STANDING PATTERNS OF PRACTICE.

IF DRG'S ARE SUCCESSFUL, HOSPITALS MAY SLOW THEIR ACQUISITION OF HIGH TECHNOLOGY PRODUCTS. IF THE PHYSICIAN SUPPLY CONTINUES TO GROW, HOSPITALS WILL BE HARD-PRESSED TO ARGUE THE NEED FOR HIGH-TECH IN ORDER TO ATTRACT AND KEEP PHYSICIANS. HOSPITALS MAY BE ABLE TO PICK AND CHOOSE PHYSICIANS.

IF DRG'S SPREAD TO A STATE-WIDE BASIS, AS HAS HAPPENED IN SOME STATES ALREADY, THEN EFFECTS ON EMPLOYEE BENEFIT PLANS WILL VARY:

- PLANS WITH LOW LENGTHS OF STAYS WILL SUFFER COST INCREASES:
- PLANS WITH HIGH LENGTHS OF STAY WILL ENJOY COST REDUCTIONS:
- PLANS WITH HMO ENROLLEES MAY SUFFER COST INCREASES.

BENEFIT PLAN EFFORTS WILL HAVE TO BE DEVOTED TO REDUCING HOSPITAL ADMISSION RATES.

IF COST-REDUCTION INITIATIVES IN EMPLOYEE BENEFIT PLANS ARE SUCCESSFUL, THEN THERE WILL BE A REDUCED DEMAND FOR PHYSICIANS, EXACERBATING THE PHYSICIAN SUPPLY PROBLEM. AND, IF COST REDUCTION INITIATIVES ARE SUCCESSFUL THERE WILL BE A REDUCED DEMAND FOR HOSPITAL SERVICES.

INSURANCE CARRIERS ARE BEGINNING TO ACCOMMODATE THE DEMANDS OF BUSINESS FOR INNOVATIVE APPROACHES TO UTILIZATION MONITORING AND REDUCTION. IT IS LIKELY THAT COST CONTAINMENT SKILLS AND TECHNIQUES WILL BECOME THE PRIMARY CRITERION IN THE SELECTION OF INSURANCE CARRIERS AND BENEFIT PLAN ADMINISTRATORS.

IN SHORT, THE HEALTH CARE SYSTEM IS CHANGING. THE SYSTEM IS CREATING CHANGE AND RESISTING CHANGE. THE MAJOR FORCES ARE BEGINNING TO TAKE ON DIFFERENT ROLES.

IT WOULD APPEAR THAT THE HEALTH CARE SYSTEM OF THE FUTURE WILL BE CHARACTERIZED BY AN OVERSUPPLY OF HOSPITALS AND PHYSICIANS AND BY AN UNDERSUPPLY OF PATIENTS.

ON THE FACE OF IT, AN OVERSUPPLY OF PROVIDERS AND AN UNDERSUPPLY OF PATIENTS SEEMS TO BE JUST WHAT THE DOCTOR ORDERED. BUT ALL WE HAVE TO DO TO UNDERSTAND THE FOLLY OF BIDING OUR TIME UNTIL COMPETITIVE FORCES SAVE THE SYSTEM IS TO RECALL THE EVENTS OF THE PAST TWENTY YEARS.

ON THE BASIS OF EVERY THEORY, HEALTH CARE COSTS SHOULD NOT BE A PROBLEM TODAY. YET HEALTH CARE COSTS ARE ONE OF OUR MOST INTRACTABLE PROBLEMS TODAY.

TO BORROW FROM THE MEDICAL JARGON, OUR PATIENT - THE HEALTH CARE SYSTEM - IS SICK: BUT FAR FROM TERMINAL. WE HAVE THE TOOLS TO DIAGNOSE THE PATIENT'S ILLNESS - WE CAN PRESCRIBE CURES - AND WE CAN GET THE PATIENT BACK ON ITS FEET AGAIN. THAT IS THE TASK WE FACE.

HEALTH CARE COST CONTAINMENT TECHNIQUES

COST REDUCTION

COST REDUCTION REFERS TO MEASURES THAT ENCOURAGE BEHAVIORAL CHANGE. COST REDUCTION WILL LEAD TO A MORE COST EFFECTIVE DELIVERY OF MEDICAL CARE AND HEALTHIER EMPLOYEE POPULATION. SPECIFIC TECHNIQUES INCLUDE:

- EMPLOYEE ATTITUDE ASSESSMENT
- WELLNESS PROGRAMS
  - PHYSICAL FITNESS
  - NUTRITION
  - CORRECTION OF SUBSTANCE ABUSE
  - STRESS REDUCTION
- ALTERNATIVE DELIVERY SYSTEMS
  - HMO's
  - PPO's
- PROVIDER PRICE CATALOGS
- MANAGED HEALTH CARE
  - PRECERTIFICATION OF ELECTIVE HOSPITAL ADMISSIONS
  - CONCURRENT UTILIZATION REVIEW
  - DISCHARGE PLANNING
  - PRE-ADMISSION TESTING
  - TARGETED SECOND SURGICAL OPINIONS
  - TARGETED AMBULATORY SURGERY PROGRAM
- ALTERNATIVE CARE SETTINGS

- EXTENDED CARE FACILITIES
- HOME HEALTH CARE
- HOSPICE CARE

- REIMBURSEMENT BASED ON DIAGNOSIS-RELATED GROUPS (DRG'S)
- EMPLOYEE COMMUNICATIONS

COST SHARING

COST SHARING REFERS TO INCREASING THE PORTION OF HEALTH CARE COSTS BORNE BY EMPLOYEES. COST SHARING CREATES AN INCENTIVE FOR EMPLOYEES TO BECOME MORE COST CONCIOUS AND PRODUCES QUICK AND DRAMATIC REDUCTIONS IN EMPLOYER COSTS. SPECIFIC TECHNIQUES INCLUDE:

- HIGHER DEDUCTIBLES
- HIGHER EMPLOYEE CO-INSURANCE
- HIGHER EMPLOYEE CONTRIBUTIONS
- HIGHER OUT-OF-POCKET MAXIMUMS
- DOLLAR LIMITS ON PROCEDURES
- RELATE PLANS
- FLEXIBLE BENEFIT PLANS
- FLEXIBLE SPENDING ACCOUNTS

COST MANAGEMENT

COST MANAGEMENT REFERS TO ADMINISTRATIVE AND FUNDING CONTROLS WHICH CAN HELP CONTAIN HEALTH CARE COSTS. SPECIFIC TECHNIQUES INCLUDE:

- ANALYSIS AND MONITORING OF PLAN UTILIZATION
- COORDINATION OF BENEFITS ADMINISTRATION
- REASONABLE AND CUSTOMARY GUIDELINES
- CLAIM PAYMENT AUDITS
- HOSPITAL BILL AUDITS
- IMPROVEMENT OF ELIGIBILITY VERIFICATION
- PROMPT PAYMENT DISCOUNTS
- FUNDING ALTERNATIVES
  - RESERVE CHANGES
  - ADMINISTRATIVE SERVICES ONLY (ASO) COTRACTS
  - RETROSPECTIVE PREMIUM ARRANGEMENTS
  - PREMIUM LAGS
  - STOP-LOSS COVERAGE
  - 501(C)(9) TRUSTS
  - ADMINISTRATOR PERFORMANCE INCENTIVES